



Medicaid Enterprise
Department of Human Services

For Human Services use only:
General Letter No. 8-AP-281
Employees' Manual, Title 8
Medicaid Appendix

November 23, 2007

LOCAL EDUCATION AGENCY MANUAL TRANSMITTAL NO. 07-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: **LOCAL EDUCATION AGENCY MANUAL**, Title page, revised; Table of Contents, new; Chapter III, *Provider-Specific Policies*, Title page, new; Table of Contents (pages 1, 2, and 3), new; pages 1 through 98, new; and the following forms:

RC-0080	<i>Screening Components by Age</i> , new
CMS-1500	<i>Claim Form</i> , revised
470-3969	<i>Claim Attachment Control</i> , revised
RA-1500	<i>Remittance Advice</i> , revised
470-3816	<i>Medicaid Billing Remittance</i> , revised

Summary

Chapters on coverage and limitations and on billing and payment for local education agency services are combined and revised to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters.

Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make the chapters quicker to load on line and easier to read and update.

This release:

- ◆ Adds a code for behavior services provided to two or more.
- ◆ Reflects a change in coding for psychologist service due to revised CPT codes.
- ◆ Adds a modifier to indicate escort service to a group.
- ◆ Transmits the revised *Billing Remittance* form.
- ◆ Clarifies a license from IDPH is required for an audiologist and speech-language pathologist to be covered by Medicaid.
- ◆ Clarifies that audiometrist services are not billable to Medicaid.
- ◆ Deletes the IA Child Mental Health Screen and recommends the Pediatric Symptom Checklist.
- ◆ Clarifies that teaching Braille is considered an educational service and not covered.

Effective Date

September 1, 2007

Material Superseded

Remove the entire Chapter E and Chapter F from the **LOCAL EDUCATION AGENCY MANUAL** and destroy them. This includes the following:

<u>Page</u>	<u>Date</u>
Title Page	Undated
Contents (p. 4)	July 1, 2004
Contents (p. 5)	October 1, 2003
Contents (p. 6)	July 1, 2003
Contents (p. 7)	March 1, 2001
Chapter E	
1-4	March 1, 2001
5	October 1, 2003
6-8	July 1, 2004
9	March 1, 2001
10	February 1, 2003
11, 12	July 1, 2004
13	March 1, 2001
14	February 1, 2003
15	March 1, 2001
16	July 1, 2003
17, 18	July 1, 2004
19, 20	March 1, 2001
21, 22	July 1, 2004
23	March 1, 2001
24	February 1, 2003
25, 26	July 1, 2004
27-29	October 1, 2003
30, 31	July 1, 2004
32-35	October 1, 2003
36, 37	July 1, 2004
38	October 1, 2003
41-47	March 1, 2001
48-50 (470-3165)	8/95
51-56	March 1, 2001
57, 58, 61, 62	July 1, 2003
63-65	March 1, 2001
66-69	July 1, 2003
70-78	July 1, 2004
79	July 1, 2003
80, 81	March 1, 2001
82-85	July 1, 2003
86-88	July 1, 2004
89-94	July 1, 2003
95	July 1, 2004
96	October 1, 2003
97	July 1, 2003
98	October 1, 2003

99-103	July 1, 2003
Chapter F	
1-3	March 1, 2001
4	February 1, 2003
5-7	March 1, 2001
8	July 1, 2003
9, 10 (HCFA-1500)	12/90
10a (470-3969)	7/03
11, 12	March 1, 2001
13 (Remittance Advice)	Undated
15-17	March 1, 2001
18	February 1, 2003
19 (470-3744)	10/02
21 (470-0040)	10/02
23	March 1, 2001
24 (470-3816)	7/05

Additional Information

The updated provider manual containing the revised pages can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise Provider Services Unit.



Medicaid Enterprise

Iowa Department of Human Services

Local Education Agency Provider Manual


 Medicaid Enterprise Department of Human Services	Provider Local Education Agency	Page 1
		Date September 1, 2007

TABLE OF CONTENTS

Chapter I. General Program Policies

Chapter II. Member Eligibility

Chapter III. Provider-Specific Policies

Appendix



Medicaid Enterprise

Iowa Department of Human Services

III. Provider-Specific Policies


 Medicaid Enterprise Department of Human Services	Provider Local Education Agency	Page 1
		Date September 1, 2007

TABLE OF CONTENTS


Page

CHAPTER III. PROVIDER-SPECIFIC POLICIES.....	1
A. CONDITIONS OF PARTICIPATION	1
1. Personnel	1
2. Records.....	1
B. COVERAGE OF SERVICES.....	2
1. Primary and Preventive School Health Services	2
a. Free Health Care	3
b. Primary Health Care Services	3
c. Preventive Services.....	4
2. Treatment Plan Requirements for IEP Services	4
3. Audiological Services	5
a. Audiological Screening.....	5
b. Individual Audiological Assessment	5
c. Direct Audiological Service to an Individual	6
d. Direct Audiological Service in a Group.....	7
4. Behavior Services	7
a. Requirements for Service.....	7
b. Progress Notes	8
5. Consultation Service.....	8
6. Medical Supplies and Equipment	8
7. Medical Transportation and Escort Services	9
8. Nursing Services.....	10
a. Screening	10
b. Individual Assessment.....	11
c. Nursing Service to an Individual	11
d. Nursing Service to a Group	12
e. Nursing Care Procedures.....	12
9. Nutrition Counseling.....	13
10. Occupational Therapy	14
a. Occupational Therapy Screening	15
b. Individual Occupational Therapy Assessment	15
c. Direct Occupational Therapy Service.....	16
d. Direct Occupational Therapy Service in a Group	18
11. Personal Health Services.....	18



Page

12.	Physical Therapy	19
a.	Physical Therapy Screening	19
b.	Individual Physical Therapy Assessment	20
c.	Direct Physical Therapy to an Individual	20
d.	Direct Physical Therapy Service in a Group	22
13.	Psychological Services	22
a.	Psychological Screening	23
b.	Individual Psychological Assessment	23
c.	Direct Psychological Service to an Individual	23
d.	Direct Psychological Service in a Group	24
14.	Service Coordination	24
a.	Who May Provide Service Coordination	26
b.	Service Documentation	26
15.	Social Work Services	27
16.	Speech-Language Therapy	28
a.	Speech-Language Screening	29
b.	Individual Speech-Language Assessment	29
c.	Direct Speech-Language Service to an Individual	29
d.	Direct Speech Therapy Service in a Group	31
17.	Vision Services	32
18.	Service Exclusions	33
C.	CONTENT OF SCREENING EXAMINATION	34
1.	History and Guidance	35
a.	Comprehensive Health and Developmental History	35
b.	Developmental Screening	35
c.	Mental Health Assessment	38
d.	Health Education/Anticipatory Guidance	40
2.	Physical Examination	45
a.	Growth Measurements	46
b.	Head Circumference	48
c.	Blood Pressure	49
d.	Oral Health Screening	52

 Medicaid Enterprise Department of Human Services	Provider	Page
	Local Education Agency	3
		Date
		September 1, 2007

Page

3.	Laboratory Tests	53
a.	Hemoglobin and Hematocrit	53
b.	Urinalysis	54
c.	Newborn Screening	55
d.	Hemoglobinopathy Screening	55
e.	Tuberculin Testing	56
f.	Lead Testing	56
g.	Cervical Papanicolaou (PAP) Smear	64
h.	Gonorrhea Test	65
i.	Chlamydia Test	65
4.	Other Services	65
a.	Immunization.....	65
b.	Nutritional Status	66
c.	Vision	70
d.	Hearing.....	73
D.	BASIS OF PAYMENT.....	74
E.	PROCEDURE CODES AND NOMENCLATURE	74
F.	CLAIM FORM	84
1.	Instructions for Completing the CMS-1500 Claim Form.....	84
2.	Claim Attachment Control, Form 470-3969.....	93
G.	REMITTANCE ADVICE	93
1.	Remittance Advice Explanation	93
2.	Remittance Advice Sample and Field Descriptions.....	95
H.	MEDICAID BILLING REMITTANCE	98



CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS OF PARTICIPATION

Local education agencies eligible to participate in the Iowa Medicaid program are the public school districts accredited by the Iowa Department of Education, the Iowa Braille and Sight-Saving School, and the School for the Deaf.

The provider must agree to remit to the Iowa Department of Human Services an amount equal to the nonfederal share of the Medicaid payment.

1. Personnel

Services shall be provided by personnel who meet standards as set forth in Iowa Department of Education rule 281 Iowa Administrative Code 41.8(256B, 34CFR300), to the extent that their certification or license allows them to provide these services. Additionally, some practitioners are required to hold a professional license.


2. Records

Providers shall maintain complete and legible clinical records documenting that the services for which a charge is made to the Medicaid program are:

- ◆ Medically necessary,
- ◆ Consistent with the diagnosis of the patient's condition, and
- ◆ Consistent with professionally recognized standards of care.

The documentation for each "patient encounter" shall include the following (when appropriate):

- ◆ Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.
- ◆ Specific procedures or treatments performed.
- ◆ Medications or other supplies.
- ◆ Patient's progress, response to and changes in treatment, and revision of diagnosis.
- ◆ Information necessary to support each item of service reported on the Medicaid claim form.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 2
		Date September 1, 2007

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to client medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

Client rights of confidentiality are respected in accordance with the provisions of 42 CFR Part 431, Subpart F, and Iowa Code Section 217.30.

B. COVERAGE OF SERVICES

Medicaid payment will be made for medically necessary audiology, behavioral, medical transportation, nursing, nutrition, occupational therapy, personal assistance, physical therapy, psychologist, school based visit, service coordinator, speech-language, social work, and vision services provided by an local education agency. Screening, assessment, and direct services are also covered.

1. Primary and Preventive School Health Services

A school health center provides primary and preventive medical, social, mental health, and health education services designed to meet the psychosocial and physical health needs of students in the context of their family, culture, and environment. Services must be within the scope of licensure of the individual practitioner.

Student health center services shall be in addition to those provided by the medical home for the student. The student health center shall coordinate services with the student's private medical provider. Students must have a medical home. If the student does not have a medical home, the student health center will work with the student and family to establish a consistent source of medical care.



a. Free Health Care

School districts may not bill Medicaid for health care services that they provide free of charge to non-Medicaid students. If a school district establishes a fee schedule for billing families for health care services, the services are not considered free, and Medicaid may be billed.

EXCEPTION: Health care services provided under Part B of IDEA that are referenced in an individual education plan (IEP) may be billed to Medicaid regardless of whether there is a charge for the service for non-Medicaid students. This includes medical transportation services that are included in the student's IEP.

b. Primary Health Care Services

Primary health care services are billed to Medicaid based on whether the student is a "new patient" or an "established patient."


Office or other outpatient (school-based) visits for the evaluation and management of a "new patient" require three components:

- ◆ A history
- ◆ An examination
- ◆ Medical decision making

The level of the components and the expected time involved varies with the severity of the student's problem.

Severity	History	Exam	Decisions
Self-limited or minor	Problem-focused	Problem-focused	Straightforward
Low to moderate	Extended problem-focused	Expanded problem-focused	Straightforward or low complexity
Moderate to high	Detailed or comprehensive	Detailed or comprehensive	Moderate or high complexity

For a student who is an "established patient," a visit requires at least two of these three components (except when the problem is minimal and requires only a few minutes performing or supervising the service). Visits with "established patients" typically take less time.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	4 <hr/> Date September 1, 2007

Covered services include counseling and coordination of care with other providers or agencies, consistent with the nature of the student's problems.

c. **Preventive Services**

Preventive services are billed on the basis of the age of the student and whether the service is the initial evaluation and management of a "new patient" or the periodic reevaluation and management of an "established patient." Covered services include:

- ◆ A comprehensive history
- ◆ A comprehensive examination
- ◆ Counseling and anticipatory guidance
- ◆ Interventions to reduce risk factors
- ◆ Ordering appropriate laboratory and diagnostic procedures

NOTE: Comprehensive physical examinations provided to Medicaid members must meet the requirements of the EPSDT "Care for Kids" program. See [CONTENT OF SCREENING EXAMINATION](#), for details.


2. **Treatment Plan Requirements for IEP Services**

All services must be specific to a Medicaid-eligible student who has an individual educational plan (IEP).

A treatment plan (IEP) is required for direct services, based on professional assessment. The treatment plan must indicate measurable goals and objectives and the type and frequency of services provided.

An updated IEP that delineates the need for ongoing services is required annually. The updated plan must:

- ◆ Include the student's current level of functioning.
- ◆ Set new goals and objectives when needed.
- ◆ Delineate the modified or continuing type and frequency of service.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	5 <hr/> Date September 1, 2007

3. Audiological Services

The following services are covered when they are included in the IEP or are linked to a service in the IEP:

- ◆ [Audiological screening](#)
- ◆ [Individual audiological assessment](#)
- ◆ [Direct audiological service to an individual](#)
- ◆ [Direct audiological service in a group](#)

To be covered by Medicaid, audiological services, including contracted audiological services, must be provided by a licensed audiologist.

Contracted audiological therapy services include screening, assessment and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, educational certification or licensure, and medical necessity remain unchanged.

a. Audiological Screening

Hearing screening must be performed by a licensed audiologist.

Objective audiological screening must be performed in both ears using a pure-tone audiometer:


- ◆ At a minimum of 500, 1000, 2000, and 4000 Hz,
- ◆ At a maximum of 25 dB HL at any one frequency.

If a student fails to respond at any of the four frequencies in either ear, a complete audiogram or other assessment must be done.

b. Individual Audiological Assessment

Individual audiological assessment includes tests, tasks, and interviews used to:

- ◆ Identify hearing loss in students.
- ◆ Establish the nature, range, and degree of the hearing loss.
- ◆ Make referral for medical or other professional attention for the habilitation of hearing.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 6
		Date September 1, 2007


c. **Direct Audiological Service to an Individual**

Direct audiological service to an individual is provided in a 1:1 therapist-to-student ratio. The type and level of treatment services are a direct outcome of the assessment. Services may be provided directly to the student or through case consultation.

Direct service includes:

- ♦ **Auditory training:** Sound discrimination tasks (in quiet noise), sound awareness, and sound localization.
- ♦ **Audiology treatment:** Services to students and their families, including:
 - Rehabilitative services to hearing-impaired students, including language habilitation, auditory training, speech reading (lip reading), speech conservation, and ongoing hearing evaluation.
 - Counseling and guidance of students, parents, and teachers regarding hearing loss and the proper care and use of amplification.
 - Determination of the student's need for group and individual amplification (hearing aids, auditory trainers, and other types of amplification).
 - Selection and fitting appropriate amplification.
 - Monitoring the functioning of the student's hearing aid or other amplification.
 - Evaluation of the effectiveness of amplification.
 - Adjustment or modification of hearing aids and other amplification.
 - Repair of amplification.
 - Making recommendation for new hearing aids or other amplification.

The role of **consultation** is monitoring, supervising, teaching, and training professionals, paraprofessionals and parents in the educational, home, or community environment.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 7
		Date September 1, 2007

Case consultation includes:

- ◆ Providing general information about a specific student's handicapping condition.
- ◆ Teaching special skills necessary for proper care of a specific student's hearing aid.
- ◆ Developing, maintaining, and demonstrating use and care of adaptive or assistive devices for a specific student.
- ◆ Making recommendations for enhancing a specific student's performance in education environments.

d. Direct Audiological Service in a Group

Direct audiological service provided in a group is identical in scope to the direct service activities listed under direct services to an individual, except that services are provided to a group of students not to exceed a 1:5 school audiologist-to-student ratio.

4. Behavior Services


Behavior services consist of formal programs designed to prevent or correct maladaptive behavior on the part of the student. The interventions are used to change specific behaviors. They are monitored by a mental health professional, and are carried out by staff.

The behavior plan must be in a separate document from just a goal in the IEP. The plan provides a description of the behavior to be addressed and positive or negative incentives to encourage proper behavior. Direct care staff record the nature and severity of the problem behaviors and the response of the direct care staff and the student. The documentation provides the basis for evaluation and revision of the plan as necessary.

a. Requirements for Service

Behavior services can be covered when:

- ◆ They can reasonably be expected to improve the student's condition. At a minimum, the treatment must be designed to reduce or control the student's psychiatric symptoms so as to:
 - Prevent relapse or hospitalization and
 - Improve the student's level of functioning.
- ◆ The student has the capacity to benefit from the treatment goals.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 8
		Date September 1, 2007

- ◆ The student does not require isolation, seclusion, elopement precautions, or restraint procedures, except for brief behavioral management.

b. Progress Notes

Progress notes must:

- ◆ Give a full picture of the services provided.
- ◆ Contain a concise assessment of the student's and family progress and recommendations for revising the treatment plan as indicated by the student's condition.

Each unit of service shall be documented. A clinical service note that summarizes program participation and behavioral status and functioning can be documented weekly. At a minimum, the documentation must address the following items in order to provide a clinical description and to assure that the service conforms to the service description.

- ◆ A general observation of the student's condition. This may include the student's mental status, behavior, and psychosocial skills.
- ◆ The student's activity and participation in treatment.
- ◆ Activities of staff.
- ◆ Future plans for working with the student.


Documentation of the treatment services provided to the student, the student's response (progress or lack of progress), and the staff's interaction and involvement with the student shall justify and support the continuation of services.

5. Consultation Service

Contracted services with a physician to obtain a specialized evaluation or reassessment are covered.

6. Medical Supplies and Equipment

Dressings, durable medical equipment, and other supplies shall be obtained from a medical equipment dealer or pharmacy. Supplies should be incidental to the student's care, such as syringes or gloves.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	9 <hr/> Date September 1, 2007

Local education agencies are limited to supplies and equipment of no more than \$25 per month. To provide durable medical supplies and equipment in excess of the \$25 monthly limit, the agency may enroll in the Medicaid program as medical equipment dealer and bill for these supplies under a medical equipment dealer number on the CMS-1500 claim form.

7. Medical Transportation and Escort Services

Expenses for transportation of a student to and from the site of medical services are covered when the medical need for transportation is on the student's IEP. This includes transportation services to a student who:

- ◆ Resides in a geographic area within which school bus transportation is not provided, or
- ◆ Requires transportation in a vehicle specially equipped or staffed to accommodate the student's special medical needs.


Escort services are a separate billable service allowed only in connection with medical transportation. Escort services must be indicated in the IEP as assistance required for the student during transportation due to the student's physical or behavioral disability and specific needs.

If a student is able to ride on a regular school bus, but requires escort assistance, the transportation cost is not billable, but the escort service can be paid if it is noted on the IEP.

Transportation may be billed only once per day. The student must have received a medical service on that day. Calculate the number of miles from the point of origin to the service location multiplied by the cost per mile times two if return trip is provided. The total cost for that day is billed. Claims that exceed the edits must be submitted with the mileage log.

Documentation for travel must be recorded in the treatment record of the student. Trip logs may be used. Documentation must include:

- ◆ The date of service,
- ◆ The location of service,
- ◆ The point of origin of travel (location),
- ◆ Location of return travel (if provided), and
- ◆ The approximate number of miles from the point of origin to the location of service.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 10
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

8. Nursing Services

Nursing services include, but are not limited to:

- ◆ Health assessment and evaluation
- ◆ Diagnosis and planning
- ◆ Administering and monitoring medical treatments and procedures
- ◆ Consultation with physicians and other health practitioners, parents, and staff
- ◆ Individual health counseling and instruction
- ◆ Emergency intervention
- ◆ Other activities and functions within the purview of the Nurse Practice Act

Medicaid covers the following services when they are when they are in the IEP or are linked to a service in the IEP and are provided by a licensed nurse:


- ◆ [Screening](#)
- ◆ [Individual assessment \(RN service only\)](#)
- ◆ [Services to an individual](#)
- ◆ [Services to a group](#)
- ◆ [Nursing care procedures](#)

Contracted services include nursing assessment and direct services to an individual or a group that are provided by a qualified practitioner who is a contractor, rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

a. Screening

Screening is the process of assessing health status through individual or group observation, in order to identify problems and determine if further assessment is needed.

Treatment plans are required for screening services. Document referrals for evaluation or treatment services identified as a result of the screen.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	11 <hr/> Date September 1, 2007

b. Individual Assessment

“Assessment” refers to the process of data collection, observation, analysis, and interpretation for the purpose of formulating a nursing diagnosis. An initial assessment includes:

- ◆ Determining the need, nature, frequency, and duration of treatment.
- ◆ Determining the need for coordinating with other service.
- ◆ Documentation of these activities.

Additional activities include:


- ◆ **Treatment planning:** Establishing a plan of care that includes determining goals and priorities for actions that are based on the nursing diagnosis and the intervention to implement the plan of care.
- ◆ **Monitoring of treatment implementation:** Activities designed to document whether the plan of care is meeting the student’s needs by demonstrating maintenance or improvement in health status.
- ◆ **Evaluation:** Activities designed to evaluate the individual or group’s state in relation to established goals and the plan of care.

c. Nursing Service to an Individual

Services to an individual involve implementing the nursing interventions in the plan of care, including ongoing assessment, planning, intervention, and evaluation.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- ◆ Providing general information about a student’s condition.
- ◆ Teaching specific skills necessary to meet a student’s needs.
- ◆ Making recommendations to enhance a student’s performance.
- ◆ Developing, maintaining, and demonstrating use of adaptive or assistive devices for a specific student.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 12
		Date September 1, 2007

d. Nursing Service to a Group

Services to a group may include:


- ◆ **Group counseling**, which is designed to improve health status.
- ◆ **Family counseling**, which consists of sessions with one or more family members for the purposes of effecting change within the family structure to ensure the student's health needs are met.

e. Nursing Care Procedures

Services include, but are not limited to, immunizations, medication administration and monitoring, prescribed health services, and interventions identified in the Individual Education Plan.

Nursing services required for specialized health care under 281 Iowa Administrative Code 41.96(256B) include, but are not limited to:


- ◆ Catheterization:
 - Education and monitoring self catheterization
 - Intermittent urinary catheterization
 - Indwelling catheter irrigation, reinsertion, and care
- ◆ Feeding:
 - Nutrition education, monitoring, and assessment
 - Ostomy feeding
 - Ostomy irrigation, insertion, removal, and care
 - Parenteral nutrition (intravenous)
 - Specialized feeding procedures
 - Stoma care and dressing changes
- ◆ Health support systems:
 - Apnea assessment, monitoring, and care
 - Central line care, dressing change, emergency care
 - Dressing and treatment
 - Dialysis monitoring and care
 - Shunt monitoring and care
 - Ventilator monitoring, care, and emergency plan
 - Wound and skin integrity assessment, monitoring, and care

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	13 <hr/> Date September 1, 2007

- ◆ Medications: (281 Iowa Administrative Code 41.12(11) and 41.96)
 - Ongoing assessment of medications
 - Medication assessment and emergency administration
 - Administration of medications by mouth, injection (intravenous, intramuscular, subcutaneous), oral inhalation by inhaler or nebulizer, rectal or bladder instillation, eye, ear, nose, skin, ostomy, or tube
- ◆ Ostomies:
 - Ostomy care, dressing, and monitoring
 - Ostomy irrigation
- ◆ Respiratory care:
 - Oxygen monitoring and care
 - Postural drainage and percussion treatments
 - Suctioning
 - Tracheostomy tube replacement
 - Tracheostomy monitoring and care
 - Ventilator care
- ◆ Specimen collection:
 - Blood collection
 - Sputum
 - Stool
 - Urine
- ◆ Other nursing procedures:
 - Bowel and bladder monitoring, care, and intervention
 - Assessing and monitoring body systems, vital signs, and growth and development

9. Nutrition Counseling

Local education agencies are eligible for reimbursement of nutrition counseling services (medical nutrition therapy) when a nutrition problem or a condition of such severity exists that nutrition counseling beyond that normally expected as part of the standard medical management is warranted. Services must be provided by licensed dietitians who are employed by or have contracts with the local education agency.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 14
		Date September 1, 2007

Medical conditions that can be referred to a licensed dietitian include the following:


- ♦ **Inadequate or excessive growth.** Examples include failure to thrive, undesired weight loss, underweight, excessive increase in weight relative to linear growth, and major changes in weight-to-height percentile or BMI for age.
- ♦ **Inadequate dietary intake.** Examples include formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite.
- ♦ **Infant feeding problems.** Examples include poor suck or swallow, breastfeeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited information or skills of caregiver.
- ♦ **Chronic disease requiring nutritional intervention.** Examples include congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, diabetes, and gastrointestinal disease.
- ♦ **Medical conditions requiring nutritional intervention.** Examples include iron deficiency anemia, high serum lead level, familial hyperlipidemia, hyperlipidemia, and pregnancy.
- ♦ **Developmental disability.** Examples include increased risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings.
- ♦ **Psychosocial factors.** Examples include behaviors suggesting an eating disorder. Students with eating disorders should also be referred to community resources and their primary care provider for evaluation and treatment.

This is not an all-inclusive list. Other diagnoses may be appropriate.

10. Occupational Therapy

The following occupational therapy services are covered when they are in the IEP or are linked to a service in the IEP:

- ♦ [Occupational therapy screening](#)
- ♦ [Individual occupational therapy assessment](#)
- ♦ [Direct occupational therapy service to an individual](#)
- ♦ [Direct occupational therapy service in a group](#)

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 15
		Date September 1, 2007

To be covered, the service must be provided by:

- ◆ A licensed occupational therapist, or
- ◆ A licensed occupational therapy assistant as delegated and supervised by the licensed occupational therapist.

Contracted occupational therapy services include screening, assessment and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

a. Occupational Therapy Screening

Screening is the process of surveying a student through direct and indirect observation in order to identify previously undetected problems. Screening may include, but is not limited to, the use of any of the following methods:


- ◆ Review of written information (school or medical records, teacher notes).
- ◆ Review of spoken information (interview teachers or parents).
- ◆ Direct observation (checklists, a comparison with peers).
- ◆ Formal screening tools.

Occupational therapists may be involved in screening a group of students, but more typically, the therapist consults and provides in-service for other school personnel who regularly screen groups of students.

b. Individual Occupational Therapy Assessment

An assessment by an occupational therapist should consider information from each of the following areas as they affect the student's ability to meet the demands of the educational program:

- ◆ Developmental motor level
- ◆ Neuromuscular and musculoskeletal components
- ◆ Functional motor skills:
 - Self-care
 - Mealtime skills
 - Manipulation skills

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	16 Date September 1, 2007

c. **Direct Occupational Therapy Service**

Direct occupational therapy to an individual includes services indicated in the treatment plan. Occupational therapy service may be provided through the following models.

(1) Direct Service Model

In a direct service model, the therapist works with a student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting.


The therapist or an assistant under the supervision of the therapist is the primary provider of service and is accountable for specific treatment plan short-term objectives for the student. There is not an expectation that activities will be delegated to others and carried out between therapy sessions.

The emphasis of direct therapy is usually on the acquisition of basic motor or sensorimotor patterns or sequences needed for new motor performance during a critical learning period. The student has not achieved a level of ability that would permit transfer of skills to other environments.

Typically, direct service is used when frequent program changes are needed and other personnel do not have the unique expertise to make these decisions. The therapist's professional judgment determines when a licensed therapist is the only person qualified to carry out the therapy program.

Intervention sessions may include the use of therapeutic or specialized equipment that require the therapist's expertise and cannot safely be used by others within the student's educational environment.

Often, only a short interval of direct service is needed before the student can participate in a less restrictive model of service.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	17 Date September 1, 2007

(2) Integrated Service Model

The integrated therapy service model combines direct student-therapist contact with consultation with others involved in the student's educational program.

Emphasis is placed on the need for practice of motor skills and problem solving in the student's daily routine. Integrated therapy service is provided within the student's daily educational environment.

The process of goal achievement is shared among those involved with the student, including the therapist, therapist assistant, teacher, parents, classroom associate, and others. Intervention may include:


- ◆ Adapting functional activities, usually occurring in the student's routine related to mobility, self-care, mealtime skills, or manipulation.
- ◆ Creating opportunities for the student to practice new motor skills.
- ◆ Dynamic positioning.
- ◆ Collaborative problem solving with others to encourage motor functioning and independence.

Only the actual time spent providing service by the therapist or an assistant under the supervision of a therapist is considered therapy. Activities or follow-through performed by others cannot be called occupational therapy.

(3) Consultative Service Model

In the consultative occupational therapy service model, the therapist participates in collaborative consultation with the teacher, other staff, parents, and, when appropriate, the student regarding student-specific issues as identified in the IEP goals and objectives.

Occupational therapy appears on the IEP as a support service and is associated with a specific IEP goal or objective.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	18 <hr/> Date September 1, 2007

The therapist's unique expertise is often needed for staff and parent training related to the IEP goal or objective. Although the therapist is not the primary person responsible for carrying out these activities, the therapist's input is typically needed to determine:

- ♦ Appropriate expectations.
- ♦ Environmental modifications.
- ♦ Assistive technology.
- ♦ Possible learning strategies.

The intervention activities, which are delegated to others, do not require the therapist's expertise and should not be identified as occupational therapy.

d. Direct Occupational Therapy Service in a Group


Direct occupational therapy to a group includes the same models as described for direct occupational therapy service to an individual.

11. Personal Health Services

Personal health services include assistance with communication, eating, personal hygiene, mobility, bladder and bowel requirements, and medication administration. The services must be included in a treatment plan developed by the licensed health care professional, but provided by paraprofessional staff.

Personal health services are services related to a student's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, and taking medications.

Personal health services primarily involve "hands on" assistance with a student's physical dependency needs. Services may include assistance with preparation of meals but do not include the cost of the meals themselves.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 19
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

12. Physical Therapy

The following physical therapy services are covered when they are in the IEP or are linked to a service in the IEP:

- ◆ [Physical therapy screening](#)
- ◆ [Individual physical therapy assessment](#)
- ◆ [Direct physical therapy service to an individual](#)
- ◆ [Direct physical therapy service in a group](#)

To be covered, the service must be provided either by:

- ◆ A licensed physical therapist, or
- ◆ A licensed physical therapist assistant as delegated and supervised by the licensed physical therapist.


Contracted physical therapy service include screening, assessment and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

a. Physical Therapy Screening

Screening is the process of surveying a student through direct and indirect observation in order to identify previously undetected problems. Screening may include, but is not limited to, the use of any of the following methods:

- ◆ Review of written information (school or medical records, teacher notes).
- ◆ Review of spoken information (interview teachers or parents).
- ◆ Direct observation (checklists, a comparison with peers).
- ◆ Formal screening tools.

Physical therapists may be involved in screening a group of students, but more typically, the therapist consults and provides in-service for other school personnel who regularly screen groups of students.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	20 <hr/> Date September 1, 2007

b. Individual Physical Therapy Assessment

An assessment by a physical therapist should consider information from each of the following areas as they affect the student's ability to meet the demands of the education program:

- ◆ Developmental motor level
- ◆ Neuromuscular and musculoskeletal components
- ◆ Functional motor skills:
 - Positioning
 - Mobility

Other areas may also be considered when they are related to the student's identified problem.

c. Direct Physical Therapy to an Individual


Direct physical therapy to an individual includes services indicated in the treatment plan. Physical therapy service may be delivered through the following models:

(1) Direct Service Model

In a direct service model, the therapist works with a student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting.

The therapist or an assistant under the supervision of the therapist is the primary provider of service and is accountable for specific treatment plan short-term objectives for the student. There is not an expectation that activities will be delegated to others and carried out between therapy sessions.

The emphasis of direct therapy is usually on the acquisition of basic motor or sensorimotor patterns or sequences needed for new motor performance during a critical learning period. The student has not achieved a level of ability that permits transfer of skills to other environments.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 21
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

Typically, direct service is used when frequent program changes are needed and other personnel do not have the unique expertise to make these decisions. The therapist's professional judgment determines when a licensed therapist is the only person qualified to carry out the therapy program.

Intervention sessions may include the use of therapeutic or specialized equipment that require the therapist's expertise and cannot safely be used by others within the student's educational environment.

Often, only a short interval of direct service is needed before the student can participate in a less restrictive model of service.


(2) Integrated Service Model

The integrated service model combines direct student-therapist contact with consultation with others involved in the student's educational program. The process of goal achievement is shared among those involved with the student, including the therapist, therapist assistant, teacher, parents, classroom associate, and others.

Integrated therapy service is provided within the student's daily educational environment. Emphasis is placed on the need for practice of motor skills and problem solving in the student's daily routine. Intervention may include:

- ◆ Adapting functional activities, usually occurring in the student's routine related to mobility.
- ◆ Creating opportunities for the student to practice new motor skills.
- ◆ Dynamic positioning to promote learning.
- ◆ Collaborative problem solving with others to encourage motor functioning and independence.

Only the actual time spent providing service by the therapist, or assistant under the supervision of a therapist, is considered therapy. Activities or follow-through performed by others cannot be called physical therapy.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 22
		Date September 1, 2007

(3) Consultative Service Model

In the consultative service model, the therapist participates in collaborative consultation with the teacher, other staff, parents, and when appropriate the student regarding student-specific issues as identified in the treatment plan goals and objectives.

Physical therapy appears on the treatment plan as a support service and is associated with a specific treatment plan goal or objective, although the therapist is not the primary individual responsible for carrying out these activities.

The therapist's unique expertise is often needed for staff and parent training related to the treatment plan goal or objective. The therapist's input is typically needed to determine:

- ♦ Appropriate expectations.
- ♦ Environmental modifications.
- ♦ Assistive technology.
- ♦ Possible learning strategies.

The intervention activities, which are delegated to others, do not require the therapist's expertise and should not be identified as occupational therapy.


d. Direct Physical Therapy Service in a Group

Direct physical therapy to a group includes the same models as described under direct physical therapy service to an individual.

13. Psychological Services

The following psychological services are covered when they are in the IEP or are linked to a service in the IEP:

- ♦ [Psychological screening](#)
- ♦ [Individual psychological assessment](#)
- ♦ [Direct psychological service to an individual](#)
- ♦ [Direct psychological service in a group](#)

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	23 <hr/> Date September 1, 2007

To be covered, services must be provided by a licensed or certified school psychologist.

Contracted psychological services include individual psychological assessment and direct psychological services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

a. Psychological Screening

Psychological screening is the process of surveying a student through direct observation or group testing in order to verify problems and determine if further assessment is needed.

b. Individual Psychological Assessment

"Assessment" refers to the process of collecting data for the purpose of making treatment decisions. The initial assessment includes:


- ◆ Determining the need, nature, frequency, and duration of treatment.
- ◆ Deciding the needed coordination with others.
- ◆ Documenting these activities.

Other activities include:

- ◆ **Treatment planning:** Assessment activities and procedures used to design an intervention plan.
- ◆ **Monitoring of treatment implementation:** Assessment activities and procedures designed to document student improvement during treatment provision and to adjust the intervention plan as needed.
- ◆ **Treatment evaluation:** Assessment activities and procedures designed to evaluate the summary effects of an intervention after a significant period.

c. Direct Psychological Service to an Individual

Direct psychological services to an individual involve individual therapy and consist of supportive, interpretive, insight-oriented, and directive interventions.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 24
		Date September 1, 2007

d. Direct Psychological Service in a Group

Direct psychological services to a group include the following services:

- ◆ **Group therapy** that is designed to enhance a student's socialization skills, peer interaction, expression of feelings, etc.
- ◆ **Family therapy**, which consists of sessions with one or more family members for the purposes of effecting changes within the family structure, communication, clarification of roles, etc.

14. Service Coordination

Service coordination is a comprehensive service that includes coordinating health services for the student. It is a Medicaid service that is reimbursable through the local education agency in addition to the therapy services and their corresponding evaluations.

Medicaid may be billed for ongoing service coordination only. Initial evaluation, reevaluation, and IEP development are considered educational services, not medical services.


Ongoing service coordination and the identification of the service coordinator must be on the IEP. It is provided after implementing a student's IEP. At the IEP meeting, the student or the student's parent must agree to service coordination.

Service coordination cannot be provided when another case management service with Medicaid case management components (such as home-and community-based services waiver) is being provided.

A unit of service includes at least one documented contact per quarter by the service coordinator relating to the student's ongoing service coordination.

The service coordinator shall:

- ◆ Act as the central point of contact relating to IEP services for a student.
- ◆ Have face-to-face contact with the student at least every quarter.
- ◆ Maintain contact with direct service providers and parents.
- ◆ Assist the student in gaining access to services specified in the IEP.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	25 Date September 1, 2007


- ◆ Discuss with direct service providers that the appropriate services are being provided.
- ◆ Provide a student or a student's parent or other responsible individual with information and direction that will assist the student in successfully accessing and using the services recommended in the IEP.
- ◆ Provide assistance or intervention regarding any educational, social, or medical condition, affecting the student's ability to meet the goals and objectives specified in the IEP.

Care coordination is the process of linking Medicaid members to the health care system. It is an activity that locates, coordinates, and monitors necessary and appropriate services. It centers on the process of collecting information on the health needs of the student, making referral as needed, and assisting families in activating the examination, diagnosis, treatment loop.

Activities commonly understood as allowable care coordination activities include assisting students in gaining access to services and monitoring to assure that needed services are received. It does not include payment of these services.

Care coordination related to a direct service is considered part of the direct service. Activities must be considered part of the direct service if they are included in the pre and post visit services. This direct-care-related activity should not be billed separately as care coordination service.

NOTE: CMS policy states, "payment for allowable Medicaid case management services must not duplicate payments that have been, or should have been, included as part of **direct** medical service.... Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, therefore they should not be claimed as case management. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral as a case management service. These activities are properly paid for as part of the medical service."

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	26 <hr/> Date September 1, 2007

a. Who May Provide Service Coordination

A person recommended as a student's ongoing service coordinator shall be:

- ◆ Employed by or under contract to a school district, and
- ◆ Chosen with consideration of the student's primary health condition, the student's needs, and the services recommended in the IEP.

Appropriately licensed or certified staff include: audiologist, behavior disorders special educator, dietitian, guidance counselor, registered nurse, occupational therapist, orientation and mobility specialist, physical therapist, psychologist, speech-language therapist, and social worker.


b. Service Documentation

The service coordinator must document one contact per quarter relating to service coordination. The notes will serve as documentation that the service was provided. The service must relate to the student's IEP goals.

Documentation that ongoing service coordination was provided consists of case notes that meet the following criteria:

- ◆ Date, time, and duration of contact.
- ◆ Who was contacted.
- ◆ The reason for a coordination contact.
- ◆ A brief summary of what transpired during the contact.
- ◆ An action, reaction, or decision by the coordinator.
- ◆ Signature of coordinator and license.

Billing information is student-specific.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 27
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

15. Social Work Services

Social work services include assessment, diagnosis and treatment services including, but not limited to:


- ◆ Administration and interpretation of clinical assessment instruments.
- ◆ Psychosocial history.
- ◆ Obtaining, integrating, and interpreting information about student behavior.
- ◆ Planning and managing a program of therapy or intervention services.
- ◆ Providing individual, group, or family counseling.
- ◆ Providing emergency or crisis intervention services.
- ◆ Consultation services to assist other service providers or family members in understanding how they may interact with a student in a therapeutically beneficial manner.

Medicaid covers the following services when they are in the IEP or are linked to a service in the IEP and a licensed school social worker or guidance counselor provides them:

- ◆ **Screening.** Screening is the process of surveying a student through direct observation or group testing in order to verify problems and determine if further assessment is needed.
- ◆ **Individual assessment.** "Assessment" refers to the process of collecting data for the purpose of making treatment decisions. The initial assessment includes:
 - Determining the need, nature, frequency, and duration of treatment.
 - Deciding the needed coordination with others.
 - Documenting these activities.

Additional activities include:

- **Treatment planning** means establishing treatment goals and procedures used to design an intervention plan.
- **Monitoring of treatment implementation** means activities and procedures designed to document student progress during treatment provision and to adjust the treatment plan as needed.
- **Treatment evaluation** means activities designed to evaluate the effects of an intervention after a significant period.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 28
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

- ◆ **Direct service to an individual.** Services to an individual student involve individual therapy, which may utilize any model of therapy and clinical practice.
- ◆ **Direct service in a group.** Services to a group include the following therapeutic and related services:
 - **Group therapy.** This service is designed to enhance socialization skills, peer interaction, expression of feelings, etc.
 - **Family therapy.** This service consists of sessions with one or more family members, for the purposes of effecting changes within the family structure, communication, clarification of roles, etc. The student must be present when family therapy is provided.

Contracted services include clinical assessment and direct services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

16. Speech-Language Therapy


The following speech-language services are covered when they are in the IEP or are linked to a service in the IEP:

- ◆ [Speech-language screening](#)
- ◆ [Individual speech-language assessment](#)
- ◆ [Direct speech-language service to an individual](#)
- ◆ [Direct speech-language service in a group](#)

To be covered, services must be provided by either:

- ◆ A licensed or certified speech-language pathologist, or
- ◆ A speech pathology assistant who is supervised by a licensed speech-language pathologist.

Contracted speech-language services include screening, assessment, and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged. Contracted speech-language services are covered only when provided by a licensed or certified speech-language pathologist.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 29
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

a. Speech-Language Screening

Speech-language screening is the process of surveying a student through direct supervision by a speech-language pathologist in order to identify previously undetected speech and language problems such as:

- ◆ Articulation
- ◆ Receptive and expressive language
- ◆ Voice
- ◆ Fluency
- ◆ Oral motor functioning
- ◆ Oral structure

b. Individual Speech-Language Assessment

Individual speech-language assessment refers to the process of gathering and interpreting information through:

- ◆ The administering of tests or evaluative instruments.
- ◆ Observation.
- ◆ Record review.
- ◆ Interviews with parents, teachers, and others.


Results of the assessment may identify delay or disorder in one or more of the following areas:

- ◆ Articulation
- ◆ Language
- ◆ Fluency
- ◆ Voice
- ◆ Oral motor, feeding, or both

Based on these assessments, the student's needs are identified, planned for, and documented, including the amount of services.

c. Direct Speech-Language Service to an Individual

Speech-language services include various service delivery models. All models may be used independently, in combinations, or with minor variations.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	30 <hr/> Date September 1, 2007

(1) Indirect Service Delivery Models

Indirect service delivery models indicate services provided to a student through the parent, teacher, or others in the student's environment, rather than by direct, routine contact with a speech-language pathologist.

- ♦ **Consultation** is used to remediate speech-language impairments by providing information, materials, demonstration teaching, and bibliotherapy, usually through parents and teachers.
- ♦ **Parents** or other caregivers of a student with speech-language impairments are organized with the specific goal to provide information and material support as indicated in the IEP.

(2) Direct Service Delivery Models

The following direct service delivery models may be used for speech-language services:

- ♦ **Skill building:** Skill building is used for students learning a new skill, needing more intensive instruction, requiring drill and practice and shaping through progressive approximation by a professionally trained speech-language therapist.

Activities include implementing the interventions by teaching skill, providing drill, prompting, cueing, eliciting, modeling, reinforcing, modifying, and accommodating.
- ♦ **Integrated:** A communication skill has been trained but needs to be integrated and generalized to functional settings of the classroom, home, and community. Activities include:
 - Enhancing carryover or generalization of communication skill from skill building level.
 - Functionally integrating the established communication skill within the classroom, home, and community.
 - Informing teachers of expectations to use communication skill.
 - Implementing modifications of accommodations as needed to maintain the skill in classroom, home, or community.



- ♦ **Consultative:** Skill building occurs, but a provider other than the speech-language therapist guides the meaningful change and development of the target communication skills.

Activities include regularly scheduled monitoring, goals and objectives written by the speech-language therapist, brief demonstration teaching and material provide by the speech-language therapist, and continuous evaluation of successful or unsuccessful interventions.

d. Direct Speech Therapy Service in a Group

(1) Indirect Service Delivery

Services are provided to a student through the parent, teacher, or others in the student's environment rather than by direct, routine contact with a speech-language pathologist.


In a **parent group**, a group of parents or other caregivers of students with speech-language impairments is organized with the specific goal of providing information and material support.

(2) Direct Service Delivery Models

- ♦ **Skill building:** Skill building is used for students learning a new skill, needing more intensive instruction, requiring drill and practice and shaping through progressive approximation by a professionally trained speech-language therapist.

Activities include implementing the interventions by teaching skill, providing drill, prompting, cueing, eliciting, modeling, reinforcing, modifying, and accommodating.

- ♦ **Integrated:** A communication skill has been trained but needs to be integrated and generalized to functional settings of the classroom, home, and community. Activities include:
 - Enhancing carryover or generalization of communication skill from skill building level.
 - Functionally integrating the established communication skill within the classroom, home, and community.
 - Informing teachers of expectations to use communication skill.
 - Implementing modifications of accommodations as needed to maintain the skill in classroom, home, or community.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	32 <hr/> Date September 1, 2007

- ♦ **Co-teaching:** Skill building and generalization are taught to the student as a combined effort between the speech-language therapist and the regular education teacher. Activities include:
 - Planned training by the therapist and the classroom teacher.
 - Integration of target communication skills for group lesson.
 - Rotation between small or large groups.
- ♦ **Consultative:** Skill building occurs, but a provider other than the speech-language therapist guides the meaningful change and development of the target communication skills. Activities include:
 - Regularly scheduled monitoring,
 - Goals and objectives written by the speech-language therapist,
 - Brief demonstration teaching and material provided by the speech-language therapist, and
 - Continuous evaluation of successful or unsuccessful interventions.


Because the speech-language impairment is the student's primary handicapping condition, the IEP must reflect the greatest intervention for that disability.

The IEP must reflect goals and objectives directed to remediating the speech-language problem as carried out by the teacher and the speech-language pathologist. In most cases, an adjusted program report must be filed.

17. Vision Services

Vision services include:

- ♦ Identification of the range, nature, and degree of vision loss.
- ♦ Consultation with a student and parents concerning the student's vision loss and appropriate selection, fitting or adaptation of vision aids.
- ♦ Evaluation of the effectiveness of a vision aid.
- ♦ Orientation and mobility services.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	33 <hr/> Date September 1, 2007

Medicaid covers the following services when they are they are in the IEP or are linked to a service in the IEP and are provided by personnel who are licensed or certified to provide vision services:


- ◆ **Vision screening.** Screening is the process of assessing vision through direct observation in order to identify problems and determine if further assessment is needed.
- ◆ **Vision assessment.** Assessment refers to the process of collecting data for the purpose of making treatment decisions. Assessment activities include:
 - Determining the need, nature, frequency, and duration of treatment.
 - Determining the need for coordination with other providers.
 - Documenting these activities.
- ◆ **Direct services to an individual.** Individual intervention is designed to enhance vision or orientation and mobility skills of an individual student.
- ◆ **Direct services to a group.** Group services involve two or more students and are designed to enhance vision or orientation and mobility skills of the group.

Contracted vision services include vision assessment and direct services for an individual or group that are rendered by a qualified practitioner who is a contractor, rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain the same.

18. Service Exclusions

Iowa Medicaid does not cover the following services:

- ◆ Services that are provided but are not documented in the student's treatment plan (IEP) or linked to a service in the IEP.
- ◆ Services rendered that are not provided directly to the eligible student or to a family member on behalf of the eligible student.
- ◆ Scheduled services that are not provided.
- ◆ Initial evaluations, reevaluation, and IEP development. These are considered educational services.
- ◆ Services that are **solely** instructional in nature. Teaching braille is considered an educational service.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 34
		Date September 1, 2007

- ◆ Consultation services that are not specific to an eligible student or are not consistent with the IEP.
- ◆ Services that are **solely** recreational in nature.
- ◆ Two Medicaid services provided simultaneously, except medical transportation and escort services.
- ◆ Services provided to students over age 20.
- ◆ Services included in plans under section 504 of the Rehabilitation Act of 1973.

C. CONTENT OF SCREENING EXAMINATION

A screening examination must include at least the following:

- ◆ Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
 - A developmental assessment.
 - An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination. This includes:
 - Physical growth.
 - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health.
- ◆ Health education, including anticipatory guidance.
- ◆ Hearing and vision screening.
- ◆ Appropriate laboratory tests. These shall include:
 - Hematocrit or hemoglobin.
 - Rapid urine screening.
 - Lead toxicity screening for all children ages 12 to 72 months.
 - Tuberculin test, when appropriate.
 - Hemoglobinopathy, when appropriate.
 - Serology, when appropriate.
- ◆ Oral health assessment with direct dental referral for children over age 12 months.

To view RC-0080, *Screening Components by Age*, on line, click [here](#).

Iowa Department of Human Services

Screening Components by Age

Age	Infancy							Early Childhood					Late Childhood					Adolescence			
	2-3 ¹ days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
HISTORY Initial/Internal	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAM	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
MEASUREMENTS Height/Weight Head Circumference Blood Pressure	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
NUTRITION ASSESS/EDUCATION	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH ² Oral Health Assessment Dental Referral	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
SENSORY SCREENING Vision Hearing	S O	S S	S S	S S	S S	S S	S S	S S	S S	S S	O O	O O	O O	O S	O S	O S	O O	O S	S S	O O	O S
DEVELOPMENTAL AND BEHAVIORAL ASSESSMENT ³	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
IMMUNIZATION ⁴	★		★	★	★			★	★			★	★	★	★	★	★	★	★	★	★
PROCEDURES Hgb/Hct Urinalysis Metabolic screening ⁵	★	★																	★		

KEY: ★ To be performed
S Subjective, by history

★ Perform test once during indicated time period
O Objective, by a standard testing method

Continued on next page.

HEMOGLOBINOPATHY	Only once (newborn screen) and offered to adolescents at risk.
TUBERCULIN TEST	For high-risk groups, annual testing is recommended. These are household members of persons with tuberculosis or others at risk for close contact with the disease: recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.
LEAD	Starting at 12 months, assess risk for high dose exposure.
GYNECOLOGIC TESTING	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
STD	When appropriate. (People with a history and risk factors for sexually transmitted diseases should be tested for chlamydia and gonorrhea.)
ANTICIPATORY GUIDANCE	Performed every visit.


¹ For newborns discharged in 24 hours or less after delivery.

² The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.

³ By history and appropriate physical examination, if suspicious, by specific objective developmental testing.

⁴ An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.

⁵ The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	35 Date September 1, 2007

1. History and Guidance

a. Comprehensive Health and Developmental History

A comprehensive health and developmental history is a profile of the patient's medical history. It includes an assessment of both physical and mental health development. Take the patient's medical history from the patient, if age-appropriate, or from a parent, guardian, or responsible adult who is familiar with the patient's history.

Take or update a comprehensive health and developmental history at every initial or periodic EPSDT screening visit. Include the following:

- ◆ Identification of specific concerns.
- ◆ Family history of illnesses.
- ◆ The client's history of illnesses, diseases, allergies, and accidents.
- ◆ Information about the client's social or physical environment that may affect the client's overall health.
- ◆ Information on current medications or adverse reaction/responses due to medications.
- ◆ Immunization history.
- ◆ Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background.
- ◆ Identification of health resources currently used.

b. Developmental Screening

Screening is a "brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment." The primary purpose of **developmental screening** is to identify children who may need more comprehensive evaluation.

The use of validated screening tools improves detection of problems at the earliest possible age. Each developmental screening instrument is accompanied by an interpretation and report (e.g., a score or designation as normal or abnormal). Any interventions or referrals based on abnormal findings should be documented as well.



Developmental screening for young children should include the following four areas:

- ◆ Speech and language,
- ◆ Fine and gross motor skills,
- ◆ Cognitive skills, and
- ◆ Social and emotional behavior.

In screening children from birth to six years of age, it is recommended that you select recognized instruments. The best instruments have good psychometric properties, including adequate sensitivity, specificity, validity, and reliability, and have been standardized on diverse populations.

Parents report instruments such as the *Parents' Evaluation of Developmental Status* (PEDS), *Ages and Stages Questionnaires*, and the *Child Development Review* have excellent psychometric properties and require a minimum of time.

No list of specific instruments is required for identifying developmental problems of older children and adolescents. However, the following principles should be considered in developmental screening:

- ◆ Collect information on the student's usual functioning, as reported by the student, parents, teacher, health professional, or other familiar person.
- ◆ Incorporate and review this information in conjunction with other information gathered during the physical examination.
- ◆ Make an objective professional judgment as to whether the student is within the expected ranges. Review the developmental progress of the student as a component of overall health and well-being, given the student's age and culture.
- ◆ Screening should be culturally sensitive and valid. Do not dismiss or excuse potential problems improperly based on culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.
- ◆ Screening should not result in a label or premature diagnosis being assigned to a student. Report only that a condition was referred or that diagnostic treatment services are needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.



When you or the parent has concerns or questions regarding the functioning of the student in relation to expected ranges of activities after screening, make referral for developmental assessment by professionals trained in the use of more elaborate instruments and structured tests.

Developmental surveillance is different than developmental testing. Developmental surveillance is a flexible, continuous process in which knowledgeable professionals perform skilled observations of children during the provision of health care.


Developmental surveillance is an important technique, which includes questions about the development as a part of the general developmental survey or history. It is not a “test” as such, and is not billable as a developmental screen.

A surveillance tool for children from birth through age five, the *Iowa Child Health and Developmental Record* (CHDR), is available at: <http://www.iowaepsdt.org/>.

The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental problems should have been identified and be under treatment. Focus screening on such areas of special concern as potential presence of learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills.

For further information on developmental screening, see:


- ◆ The Care for Kids Provider web site at: <http://www.iowaepsdt.org/>;
- ◆ The Developmental Behavioural Online site of the American Academy of Pediatrics at: <http://www.dbpeds.org/>;
- ◆ The Assuring Better Child Development and Health (ABCD) Electronic Resource Center of the National Academy for State Health Policy at: www.abcdresources.org;
- ◆ The Commonwealth Fund’s Child Development and Preventive Care web site at: http://www.commonwealthfund.org/programs/programs_list.htm?attrib_id=9134
- ◆ The National Center of Home Initiatives for Children with Special Needs web site of the American Academy of Pediatrics at: <http://www.medicalhomeinfo.org/screening/index.html>

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 38
		Date September 1, 2007

c. **Mental Health Assessment**

Mental health assessment should capture important and relevant information about the student as a person. It may include a psychosocial history such as:

- ◆ The student's **life-style**, home situation, and "significant others."
- ◆ A **typical day**: How the student spends the time from getting up to going to bed.
- ◆ **Religious and health beliefs** of the family relevant to perceptions of wellness, illness, and treatment, and the student's outlook on the future.
- ◆ **Sleep**: Amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.
- ◆ **Toileting**: Methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.
- ◆ **Speech**: Hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.
- ◆ **Habits**: Bed-rocking, head-banging, tics, thumb-sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.
- ◆ **Discipline**: Parental assessment of student's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- ◆ **Schooling** experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and student satisfaction; academic achievement; and school's concerns.
- ◆ **Sexuality**: Relations with members of opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to student's questions and the sex education parents have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.
- ◆ **Personality**: Degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self image.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 39
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

Source: Boyle Jr., W.E. and Hoekelman, R.A. The Pediatric History, In Hoekelman, R.A. ed. Primary Pediatric Care, Second Edition, 1992.

Clinical screening tools can increase the identification of psychosocial problems and mental disorders in primary care settings. Moreover, such tools can provide an important framework for discussing psychosocial issues with families. These screening tools can be grouped into three general categories:

- ◆ Broad psychosocial tools that assess overall functioning, family history, and environmental factors; deal with a wide range of psychosocial problems; and identify various issues for discussion with the student and family.

An example of this type of tool is the *Pediatric Intake Form*, which can be used to assess such issues as parental depression and substance use, gun availability, and domestic violence (Kemper and Kelleher, 1996a, 1996b).

- ◆ Tools that provide a general screen for psychosocial problems or risk in children and adolescents, such as the *Pediatric Symptom Checklist* (Jellinek et al., 1988, 1999).
- ◆ Tools that screen for specific problems, symptoms, and disorders, such as the *Conners' Rating Scales for ADHD* (Conners, 1997) and the *Children's Depression Inventory* (Kovacs, 1992).

Often a broader measure such as the *Pediatric Symptom Checklist* is used first, followed by a more specific tool focused on the predominant symptoms for those that screen positive on the broader measure.

Some of the more specific tools may not be readily available to primary care health professionals or may require specialized training.

Source: Jellinek M, Patel BP, Froehle MC, eds. 2002. Bright Futures in Practice: Mental Health – Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health.

To view the *Pediatric Symptom Checklist*, see

http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_symptom_chklst.pdf



d. Health Education/Anticipatory Guidance

Health education that includes anticipatory guidance is an essential component of screening services. Provide it to parents and youth (if age-appropriate) at each screening visit. Design it to:

- ◆ Assist the parents and youth in understanding what to expect in terms of the student's development.
- ◆ Provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

Health education must be age-appropriate, culturally competent, and geared to the particular student's medical, developmental, dental and social circumstances. Four lists of age-related topics recommended for discussion at screenings are included below.

Anticipatory guidance and health education recommended topics are included in the *2000 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second Edition, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 356-1964, (888) 434-4MCH, or <http://www.ncemch.org/>.

View this list as a guideline only. It does not require the inclusion of topics that are inappropriate for the student or limit topics that are appropriate for the student.

Suggested Health Education Topics: Birth - 18 Months

Oral Health

Appropriate use of bottle and breast feeding	Non-nutritive sucking (thumb, finger, and pacifier)
Fluoride exposure: toothpaste, water, topical fluoride and supplements	Teething and tooth eruption
Infant oral care: cleaning teeth and gums	First dental visit by age one
Early childhood caries	Feeding and snacking habits: exposure to carbohydrates and sugars
Transmission of oral bacteria	Use of cup and sippy cup



Injury Prevention

Infant/child CPR	Exposure to sun and heat
Child care options	Safety locks
Child safety seat restraint	Lock up chemicals
Child safety seats	Restricted play areas on the farm
Importance of protective helmets	Smoke detectors
Electric outlets	Stairway gates, walkers, cribs
Animals/pets	Syrup of ipecac, poison control
Hot water heater temperature	Emergency telephone numbers
Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder, plastic bags	Water precautions: buckets, tubs, small pools

Mental Health

Adjustment to new baby	Sibling rivalry
Balancing home, work, and school	Support from spouse and friends
Caretakers' expectations of infant development	Recognizing unique temperament
Responding to infant distress	Creating stimulating learning environments
Baby self regulation	Fostering baby caregiver attachment
Child care	

Nutrition

Bottle propping	Managing meal time behavior
Breast or formula feeding to 1 year	Self feeding
Burping	Snacks
Fluid needs	Weaning
Introduction of solid foods at 4-6 months	

Other Preventive Measures

Back sleeping	Effects of passive smoking
Bowel patterns	Fever
Care of respiratory infections	Hiccoughs
Crying or colic	Importance of well-child visits



Suggested Health Education Topics: 2 - 5 Years

Oral Health

Appropriate use of bottle and breast feeding	Teething and tooth eruption
Fluoride exposure: toothpaste, water, topical fluoride and supplements	Regular dental visits
Oral care: parental tooth brushing and flossing when the teeth touch	Feeding and snacking habits: exposure to carbohydrates and sugars
Gingivitis and tooth decay	Use of sippy cup
Non-nutritive sucking (thumb, finger and pacifier)	Dental injury prevention
	Sealants on six-year molars

Injury Prevention

CPR training	Purchase of bicycles
Booster car seat	Put up warning signs
Burns and fire	Restricted play areas
Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins	Street danger
Dangers of accessible chemicals	Teach child how to get help
Importance of protective helmets	Toys
Machinery safety	Tricycles
No extra riders on tractor	Walking to school
Play equipment	Water safety
	Gun storage

Mental Health

Adjustment to increasing activity of child	Child care
Balancing home, work, and school	Sibling rivalry
Helping children feel competent	Managing emotions

Nutrition

Appropriate growth pattern	Managing meal-time behavior
Appropriate intake for age	Physical activity
Control issues over food	Snacks

Other Preventive Measures

Adequate sleep	TV watching
Care of illness	Age-appropriate sexuality education
Clothing	School readiness
Common habits	Toilet training
Importance of preventative health visits	Smoke-free environments
Safety rules regarding strangers	
Social skills	



Suggested Health Education Topics: 6 - 12 Years

Oral Health

Fluoride exposure: toothpaste, water, topical fluoride and supplements	Regular dental visits
Oral care: supervised tooth brushing and flossing	Dental referral: orthodontist
Gingivitis and tooth decay	Diet and snacking habits: exposure to carbohydrates, sugars, and pop
Non-nutritive sucking (thumb, finger and pacifier)	Dental injury prevention
Permanent tooth eruption	Sealants on 6- and 12-year molars
	Mouth guards for sports
	Smoking and smokeless tobacco

Injury Prevention

Bicycle (helmet) safety	Emergency telephone numbers
Car safety	Machinery safety
CPR training	Mowing safety
Dangers of ponds and creeks	Self-protection tips
Electric fences	Sports safety
Farm hazards: corn cribs, grain auger, gravity flow wagon, livestock	Street safety
Fire safety	Tractor safety training
Gun and hunter safety	Water safety
	High noise levels

Mental Health

Discipline	Developing self esteem
Emotional, physical, and sexual development	Nurturing friendships
Handling conflict	Peer pressure and adjustment
Positive family problem solving	School-related concerns
	Sibling rivalry

Nutrition

Appropriate intake for age	Inappropriate dietary behavior
Breakfast	Managing meal time behavior
Child involvement with food decisions	Peer influence
Food groups	Physical activity
	Snacks

Other Preventive Measures

Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
Smoke-free environments	Stress
	TV viewing



Suggested Health Education Topics: Adolescent (13 - 21 Years)

Oral Health

Fluoride exposure: toothpaste, water and topical fluoride
Oral care: tooth brushing and flossing
Gingivitis, periodontal disease and tooth decay
Permanent tooth eruption
Regular dental visits
Dental referral: orthodontist and oral surgeon for third molars

Diet and snacking habits: exposure to carbohydrates, sugars and pop
Dental injury prevention
Sealants on 6- and 12-year molars
Mouth guards for sports
Smoking and smokeless tobacco
Drug use (methamphetamines)
Oral piercing

Development

Normal biopsychosocial changes of adolescence

Gender Specific Health

Abstinence education
Contraception, condom use
HIV counseling or referral
Self breast exam
Self testicular exam
Sexual abuse, date rape

Gender-specific sexual development
Sexual orientation
Sexual responsibility, decision making
Sexually transmitted diseases
Unintended pregnancy

Health Consumer Issues

Selection and purchase of health devices or items

Selection and use of health services

Injury Prevention

ATV safety
CPR and first aid training
Dangers of farm ponds and creeks
Falls
Firearm safety, hunting practices
Gun and hunter safety
Handling agricultural chemicals
Hearing conservation
Machinery safety
Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)

Overexposure to sun
ROPS (roll over protective structure)
Seat belt usage
Helmet usage
Smoke detector
Sports recreation, workshop laboratory, job, or home injury prevention
Tanning practices
Violent behavior
Water safety
High noise levels



Nutrition

Body image, weight issues	Food fads, snacks, fast foods
Caloric requirements by age and gender	Selection of fitness program by need, age, and gender
Balanced diet to meet needs of growth	Special diets
Exercise, sports, and fitness	

Personal Behavior and Relationships

Communication skills	Community involvement
Dating relationships	Relationships with adults and peers
Decision making	Self esteem building
Seeking help if feeling angry, depressed, hopeless	Stress management and reduction
	Personal responsibility

Substance Use

Alcohol and drug cessation	Riding with intoxicated driver
Counseling or referral for chemical abuse	Sharing of drug paraphernalia
Driving under the influence	Steroid or steroid-like use
HIV counseling and referral	Tobacco cessation

Other Preventive Measures

Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
Smoke-free environments	Stress
	TV viewing

2. Physical Examination

Perform a comprehensive unclothed physical examination at each screening visit. It should include, but is not limited to, the following:

- ◆ General appearance.
- ◆ Assessment of all body systems.
- ◆ Height and weight.
- ◆ Head circumference through 2 years of age.



- ◆ Blood pressure starting at 3 years of age.
- ◆ Palpation of femoral and brachial (or radial) pulses.
- ◆ Breast inspection and palpation for age-appropriate females, including breast self-examination instructions and health education.
- ◆ Pelvic examination, recommended for women 18 years old and older, if sexually active or having significant menstrual problems.
- ◆ Testicular examination, include age-appropriate self-examination instructions and health education.

a. Growth Measurements

- ◆ **Recumbent Length:** Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8th inch.

- ◆ **Height:** Measure children over 2 years of age using a standing height board or stadiometer. Read and record the measurement to the nearest 1/8th inch.

If the child is two years old or older and less than 31 1/2 inches tall, the height measurement does not fit on the 2 - 20 year old chart. Therefore, you must measure the child's recumbent length and plot the length on the Birth - 36 month growth chart.

Never use measuring rods attached to scales, because the surface on which the child stands is not stable, and the measuring rod's hinge tends to become loose, causing inaccurate readings.

- ◆ **Weight:** Use a balance beam scale with non-detachable weights. Calibrate the scale once a year. Infants can be measured on either a specially designed infant scale or in a cradle on the adult scale.

Weigh infants and children with a minimal amount of clothing. Read and record to the nearest ounce for infants and quarter of a pound for children and youth.

- ◆ **Body Mass Index:** Body Mass Index (BMI) is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.



1. Convert any fractions to decimals.

Examples: 37 pounds 4 ounces = 37.25 pounds

41 ½ inches = 41.5 inches

2. Insert the values into the formula:

[weight (lb) / height (in) / height (in)] X 703 = BMI

Example: (37.25 lb / 41.5 in / 41.5 in) X 703 = 15.2

A reference table can also be used to calculate BMI. This table can be downloaded from the Centers for Disease Control and Prevention web site at www.cdc.gov/growthcharts.

For children, BMI values are plotted against age. If the BMI for age is less than or equal to the 5th percentile, the child is considered underweight.

If the BMI for age is between the 85th and 94th percentiles, the child is considered to be at risk for overweight. Children with a BMI equal to or greater than the 95th percentile are considered overweight.

- ◆ **Plotting Measurements:** Record measurements as soon as they are taken to reduce errors.

Plot weight and height against age and weight against height on the Center for Disease Control and Prevention (CDC) growth chart for the children under 2 years of age. For children 2 - 20 years, plot weight and height against age and BMI against age on the appropriate growth chart.

Example of calculating child's age:

	Year		Month		Day		
Date of visit	93	92	7	6	18	15	45 July 15, 1993
Birth date	-91		-10			-28	October 28, 1991
Age	1		8			17	= 20 months, 17 days or 21 months

Borrow 30 days for the 7 in the month column to make the day column 45 and the month column 6.

Borrow 12 months for 93 in the year column so that the top number in the month column is now 18.



Calculate the age to the nearest month. (Round to the next month if over 15 days.) Subtract the birth date from the clinic visit date. You may borrow 30 days from the month column or 12 months from the year column when subtracting.

Common errors result from unbalanced scales, failure to remove shoes and heavy clothing, use of an inappropriate chart for recording the results, and uncooperative children.

◆ **Referral and Follow-up of Growth in Infants and Children:**

- Nutrition. See criteria in [Nutritional Status](#).
- Medical. Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature.

Some warning signs of growth abnormalities are as follows:


- Growth of less than 2 inches/year for ages 3 to 10 years.
- A change in weight/height percentile rank of 25 or more.
- Sudden weight gain or loss.
- More than two standard deviations below or above the mean for the child's height.

b. Head Circumference

Measure the head circumference at each visit until the child is two years old. Measure with a nonstretchable tape measure firmly placed from the maximal occipital prominence around to the area just above the eyebrow. Plot the results on the Center for Disease and Prevention (CDC) growth chart.

Further evaluation is needed if the CDC growth grid reveals a measurement:

- ◆ Above the 95th percentile.
- ◆ Below 5th percentile.
- ◆ Reflecting a major change in percentile levels from one measurement to the next or over time.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 49
		Date September 1, 2007

c. **Blood Pressure**

Blood pressure measurement is a routine part of the physical examination at three years of age and older. During infancy, do a blood pressure only if other physical findings suggest it may be needed.

Recently the National Health, Lung and Blood Institute published new blood pressure standards for children and adolescents. The new standards are based on height as well as age and gender for children and adolescents from one through 17 years old.

This is a change from the past when height and weight were both thought to be correlates of blood pressure. Height was determined by the investigators to be a better correlate for children and teenagers because of the prevalence of obesity in young people in this country. The standards appear in Tables 1 and 2.

To use these tables, you need to measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age, and sex.

The National Heart, Lung and Blood Institute recommends using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

The interpretation of children and adolescents blood pressure measurements for height, age, and gender are as follows:

- ◆ Readings below the 90th percentile are considered normotensive.
- ◆ Reading between the 90th and 95th percentile are high normal and warrant further observation and identification of risk factors.
- ◆ Readings of either systolic or diastolic at or above the 95th percentiles indicate the child may be hypertensive. Repeated measurements are indicated.



Table 1. Blood Pressure Levels for Boys Aged 1 to 17 Years by Percentile of Height

Boys		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	94	95	97	98	100	102	102	50	51	52	53	54	54	55
	95th	98	99	101	102	104	106	106	55	55	56	57	58	59	59
2 yr	90th	98	99	100	102	104	105	106	55	55	56	57	58	59	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3 yr	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	111	112	113	63	63	64	65	66	67	67
4 yr	90th	102	103	105	107	109	110	111	62	62	63	64	65	66	66
	95th	106	107	109	111	113	114	115	66	67	67	68	69	70	71
5 yr	90th	104	105	106	108	110	112	112	65	65	66	67	68	69	69
	95th	108	109	110	112	114	115	116	69	70	70	71	72	73	74
6 yr	90th	105	106	108	110	111	113	114	67	68	69	70	70	71	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
7 yr	90th	106	107	109	111	113	114	115	69	70	71	72	72	73	74
	95th	110	111	113	115	116	118	119	74	74	75	76	77	78	78
8 yr	90th	107	108	110	112	114	115	116	71	71	72	73	74	75	75
	95th	111	112	114	116	118	119	120	75	76	76	77	78	79	80
9 yr	90th	109	110	112	113	115	117	117	72	73	73	74	75	76	77
	95th	113	114	116	117	119	121	121	76	77	78	79	80	80	81
10 yr	90th	110	112	113	115	117	118	119	73	74	74	75	76	77	78
	95th	114	115	117	119	121	122	123	77	78	79	80	80	81	82
11 yr	90th	112	113	115	117	119	120	121	74	74	75	76	77	78	78
	95th	116	117	119	121	123	124	125	78	79	79	80	81	82	83
12 yr	90th	115	116	117	119	121	123	123	75	75	76	77	78	78	79
	95th	119	120	121	123	125	126	127	79	79	80	81	82	83	83
13 yr	90th	117	118	120	122	124	125	126	75	76	76	77	78	79	80
	95th	121	122	124	126	128	129	130	79	80	81	82	83	83	84
14 yr	90th	120	121	123	125	126	128	128	76	76	77	78	79	80	80
	95th	124	125	127	128	130	132	132	80	81	81	82	83	84	85
15 yr	90th	123	124	125	127	129	131	131	77	77	78	79	80	81	81
	95th	127	128	129	131	133	134	135	81	82	83	83	84	85	86
16 yr	90th	125	126	128	130	132	133	134	79	79	80	81	82	82	83
	95th	129	130	132	134	136	137	138	83	83	84	85	86	87	87
17 yr	90th	128	129	131	133	134	136	136	81	81	82	83	84	85	85
	95th	132	133	135	136	138	140	140	85	85	86	87	88	89	89

* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.



Table II. Blood Pressure Levels for Girls Aged 1 to 17 Years by Percentile of Height

GIRLS		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	97	98	99	100	102	103	104	53	53	53	54	55	56	56
	95th	101	102	103	104	105	107	107	57	57	57	58	59	60	60
2 yr	90th	99	99	100	102	103	104	105	57	57	58	58	59	60	61
	95th	102	103	104	105	107	108	109	61	61	62	62	63	64	65
3 yr	90th	100	100	102	103	104	105	106	61	61	61	62	63	63	64
	95th	104	104	105	107	108	109	110	65	65	65	66	67	67	68
4 yr	90th	101	102	103	104	106	107	108	63	63	64	65	65	66	67
	95th	105	106	107	108	109	111	111	67	67	68	69	69	70	71
5 yr	90th	103	103	104	106	107	108	109	65	66	66	67	68	68	69
	95th	107	107	108	110	111	112	113	69	70	70	71	72	72	73
6 yr	90th	104	105	106	107	109	110	111	67	67	68	69	69	70	71
	95th	108	109	110	111	112	114	114	71	71	72	73	73	74	75
7 yr	90th	106	107	108	109	110	112	112	69	69	69	70	71	72	72
	95th	110	110	112	113	114	115	116	73	73	73	74	75	76	76
8 yr	90th	108	109	110	111	112	113	114	70	70	71	71	72	73	74
	95th	112	112	113	115	116	117	118	74	74	75	75	76	77	78
9 yr	90th	110	110	112	113	114	115	116	71	72	72	73	74	74	75
	95th	114	114	115	117	118	119	120	75	76	76	77	78	78	79
10 yr	90th	112	112	114	115	116	117	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
11 yr	90th	114	114	116	117	118	119	120	74	74	75	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	79	79	80	81	81
12 yr	90th	116	116	118	119	120	121	122	75	75	76	76	77	78	78
	95th	120	120	121	123	124	125	126	79	79	80	80	81	82	82
13 yr	90th	118	118	119	121	122	123	124	76	76	77	78	78	79	80
	95th	121	122	123	125	126	127	128	80	80	81	82	82	83	84
14 yr	90th	119	120	121	122	124	125	126	77	77	78	79	79	80	81
	95th	123	124	125	126	128	129	130	81	81	82	83	83	84	85
15 yr	90th	121	121	122	124	125	126	127	78	78	79	79	80	81	82
	95th	124	125	126	128	129	130	131	82	82	83	83	84	85	86
16 yr	90th	122	122	123	125	126	127	128	79	79	79	80	81	82	82
	95th	125	126	127	128	130	131	132	83	83	83	84	85	86	86
17 yr	90th	122	123	124	125	126	128	128	79	79	79	80	81	82	82
	95th	126	126	127	129	130	131	132	83	83	83	84	85	86	86

* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.



d. Oral Health Screening

The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive dental education is provided to the parents or guardians.


Unlike other health needs, dental problems are so prevalent that most children over 12 months will need diagnostic evaluation and treatment. An oral screening that includes a medical and dental history and an oral evaluation as listed below must be documented in the child's record.

◆ Medical and dental history:

- Current or recent medical conditions
- Current medications used
- Allergies
- Name of child's physician and dentist
- Date of last dental visit or frequency of dental visits
- Use of fluoride by child (source of water, use of fluoridated toothpaste or other fluoride products)
- Current or recent dental problems or injuries
- Home care (frequency of brushing, flossing, or other oral hygiene practices)
- Snacking and feeding habits

◆ Oral evaluation

- Number of teeth (for children up to age 12)
- Presence of decay
- Presence of demineralized areas (white spots)
- Presence of visible plaque
- Presence of gingivitis or other soft tissue conditions
- Presence of enamel defects
- Presence of sealants
- Presence of restored teeth

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	53 <hr/> Date September 1, 2007

- ◆ Provide age-appropriate oral health education to the parent or guardian. Education should be based on the findings of the oral health screening.
- ◆ Refer children to a dentist for:
 - Complete dental examination annually starting at 12 months and semiannually starting at 24 months, unless a dentist recommends more frequent visits;
 - Obvious or suspected dental caries;
 - Pain or injury to the oral tissue; and
 - Difficulty chewing.

3. Laboratory Tests


a. Hemoglobin and Hematocrit

One hematocrit or hemoglobin determination is suggested by the American Academy of Pediatrics during the first year, and in each of the following intervals:

- ◆ 9-12 months, if any of the following risk factors are present:
 - Qualify for EPSDT Care for Kids
 - Low socioeconomic status
 - Birth weight under 1500 grams
 - Whole milk given before 6 months of age (not recommended)
 - Low-iron formula given (not recommended)
- ◆ 11-20 years. Annual screening for females, if any of the following factors are present:
 - Qualify for EPSDT Care for Kids
 - Moderate to heavy menses
 - Chronic weight loss
 - Nutrition deficit
 - Athletic activity

A test for anemia may be performed at any age if there is:

- ◆ Medical indication noted in the physical examination
- ◆ Nutritional history of inadequate iron in the diet
- ◆ History of blood loss
- ◆ Family history of anemia

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	54 Date September 1, 2007

All children whose hemoglobin or hematocrit is less than the fifth percentile are considered at risk for developing anemia.

Children under five years of age with incomes under 185% of poverty and hemoglobins or hematocrit below the fifth percentile qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Fifth Percent Criteria for Children

Age/Years	Hematocrit	Hemoglobin
6 months up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.5
8 up to 12 years	35.4	11.9

Female (non pregnant)

12 up to 15 years	35.5	11.8
15 up to 18 years	35.9	12.0
18 up to 21 years	35.7	12.0

Male

12 up to 15 years	37.3	12.5
15 up to 18 years	39.7	13.3
18 up to 21 years	39.9	13.5

Source: "Recommendations to Prevent and Control Iron Deficiency in the United States," *Morbidity and Mortality Weekly Report*, April 3, 1998; Vol. 47, No. RR-3, pages 1-29.

b. Urinalysis

Depending on the success in obtaining a voided urine specimen, urinalysis is suggested:

- ◆ At 5 years
- ◆ Once from 11 through 20 years, preferable at 14 years



Use a dipstick that shows at least pH, glucose, protein, blood, and nitrates. Referral criteria should include:

- ◆ PH below 5 or above 9
- ◆ Glycosuria
- ◆ 2+ protein
- ◆ Positive nitrates
- ◆ Trace or greater blood

c. Newborn Screening

Confirm during the infant's first visit that newborn screening was done. In Iowa, newborn screening is mandatory for the following conditions:

- ◆ Congenital adrenal hyperplasia
- ◆ Galactosemia
- ◆ Hemoglobinopathies
- ◆ Hypothyroidism
- ◆ Phenylketonuria (PKU)
- ◆ Medium chain acyl Co-A dehydrogenase (MCAD) deficiency
- ◆ Biotinidase deficiency
- ◆ Hearing
- ◆ Cystic fibrosis
- ◆ Any other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry

A current list of the screening panel can be found at:

<http://www.idph.state.ia.us/genetics>

d. Hemoglobinopathy Screening

Screen infants not born in Iowa and children of Caribbean, Latin American, Asian, Mediterranean, and African descent who were born before February 1988 for hemoglobin disorders. Identification of carrier status before conception permits genetic counseling and availability of diagnostic testing in the event of pregnancy.

The Hemoglobinopathy Screening and Comprehensive Care Program at the University of Iowa offers testing for a small fee. Call 319-356-1400 for information.



e. Tuberculin Testing

The American Academy of Pediatrics Committee on Infectious Disease recommends annual tuberculin skin testing in high-risk children.

High-risk children include those in households where tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, or the Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and homes of IV drug users, alcoholics, HIV positives, and prostitutes).

f. Lead Testing

Perform blood lead testing for lead toxicity on children aged 12 to 72 months of age. The goal of all lead poisoning prevention activities is to reduce children's blood lead levels below 10 µg/dL.

Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning, because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.

Initial screening may be done using a capillary specimen if procedures are followed to prevent the contamination of the sample. Consider an elevated blood level from a capillary test presumptive. Confirm it with a venous blood specimen.

For more information or assistance on lead testing, screening, or case management, contact the Bureau of Lead Poisoning Prevention, Iowa Department of Public Health, 515-281-3479 or 1-800-972-2026.

(1) Determining Risk Through Asking Questions

Beginning with the age of 12 months, ask the following questions for all children at each office visit to determine each child's risk for lead poisoning:

- ◆ Has your child ever lived in or regularly visited a house built before 1960 (including home, child care center, baby-sitter, relatives' home)?
- ◆ Have you noticed any peeling or chipping paint in or around the pre-1960 house that your child lives in or regularly visits?



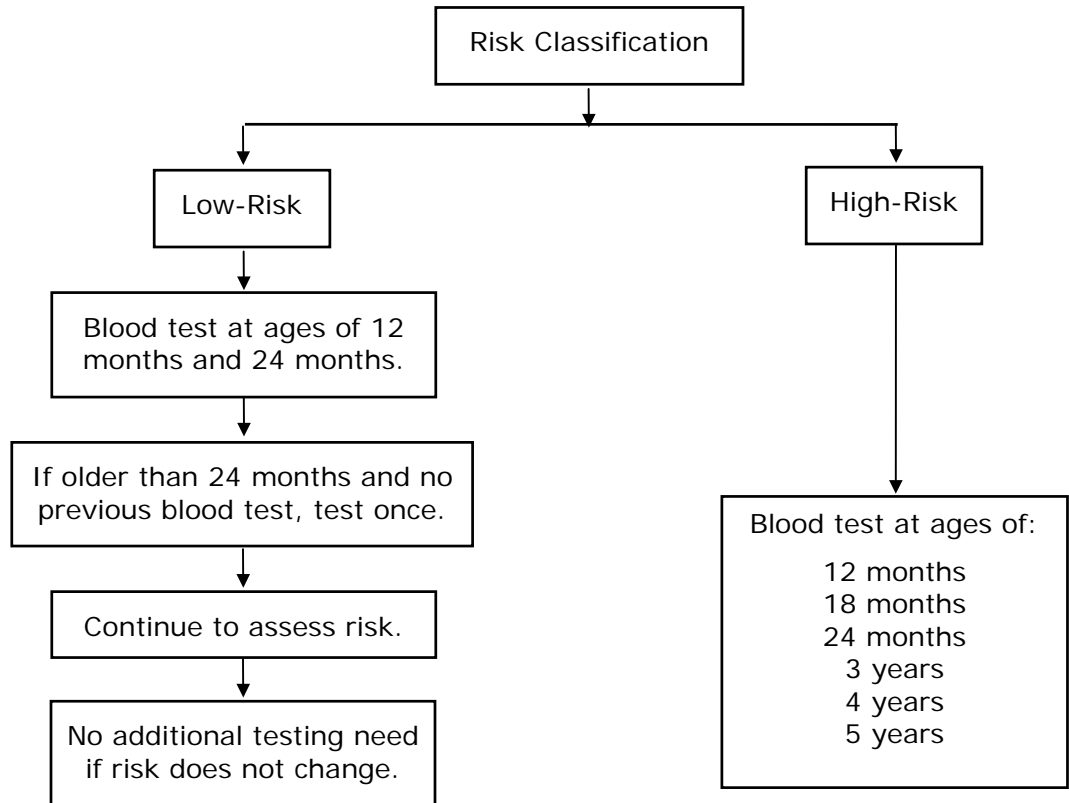
- ♦ Is the pre-1960 home that your child lives in or regularly visits being remodeled or renovated by:
 - Stripping, sanding, or scraping paint on the inside or outside of the house.
 - Removing walls or tearing out lath and plaster.
- ♦ Does your child eat non-food items, such as dirt?
- ♦ Have any of your other children or their playmates had elevated lead levels $\geq 15 \mu\text{g/dL}$?
- ♦ Does your child live with or frequently encounter an adult who works with lead on the job or in a hobby?
(Examples: painter, welder, foundry worker, old home renovator, shooting range worker, battery plant worker, battery recycling worker, ceramic worker, stained glass worker, sheet metal worker, plumber.)
- ♦ Does your child live near a battery plant, battery recycling plant, or lead smelter?
- ♦ Do you give your child any home or folk remedies? (Examples: Azarcon, Greta, Pay-loo-ah)
- ♦ Does your child eat candy that comes from Mexico or is purchased from a Mexican grocery store?
- ♦ Has your child ever lived in Mexico, Central America, or South America or visited one of these areas for a period longer than two months?

If the answer to **any** of these questions is yes, the child is considered to be at high risk for lead poisoning and must be tested according to the high-risk screening schedule.

If the parent does not know the answer, it must be assumed to be yes. If the answer to all of the questions is no, the child is considered to be at low risk for lead poisoning and must be tested according to the low-risk testing schedule.



(2) Basic Lead Testing Chart (Based on Risk and Age)



NOTE: If you see children at different ages than these, you can change these schedules to correspond with the ages when you do see children. However, the first test should not be done before 12 months unless the child is at extremely high risk for lead poisoning.

If capillary samples are used, see next page for follow-up of any level ≥ 10 $\mu\text{g/dL}$.

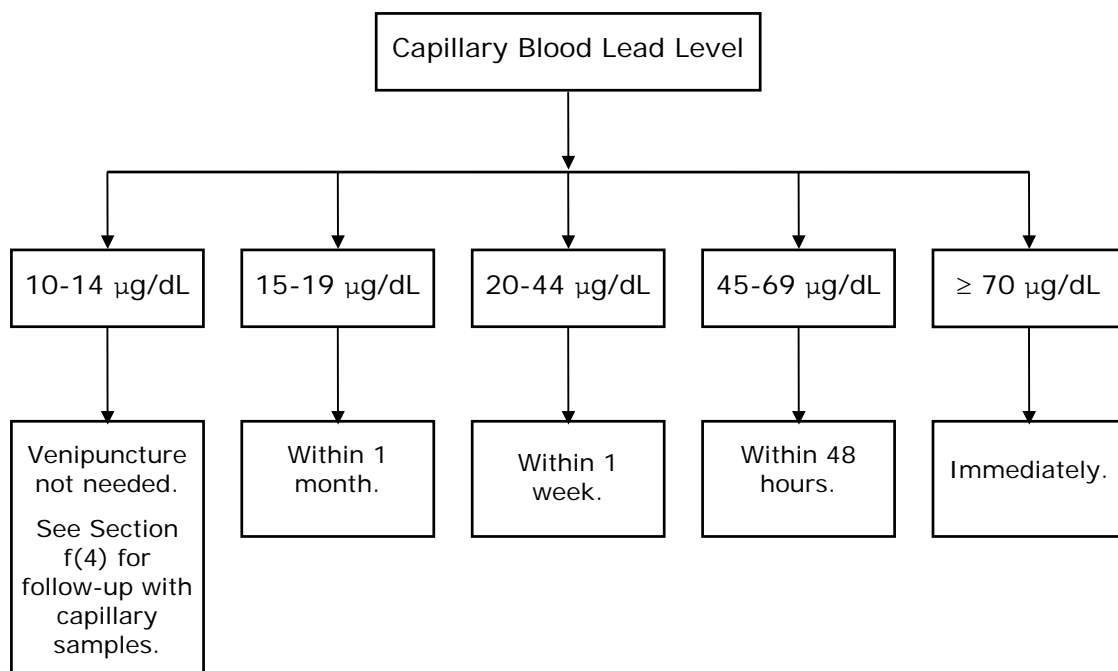
If venous samples are used, see [Follow-up of Elevated Blood Lead Levels \(10-14 \$\mu\text{g/dL}\$ \)](#), [Follow-up of Elevated Venous Blood Leads \(15-19 \$\mu\text{g/dL}\$ \)](#), and [Follow-up of Elevated Venous Levels \(\$\geq 20\$ \$\mu\text{g/dL}\$ \)](#) for follow-up of any level ≥ 10 $\mu\text{g/dL}$.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



(3) Schedule for Obtaining Confirmatory Venipunctures

Children who have blood lead levels ≥ 15 $\mu\text{g/dL}$ on a capillary sample should have these levels confirmed on venous samples according to the timetables below.



If venous level < 9 $\mu\text{g/dL}$, return to regular blood lead testing schedule.

If venous level 10-14 $\mu\text{g/dL}$, see [Follow-up of Elevated Blood Lead Levels \(10-14 \$\mu\text{g/dL}\$ \)](#).

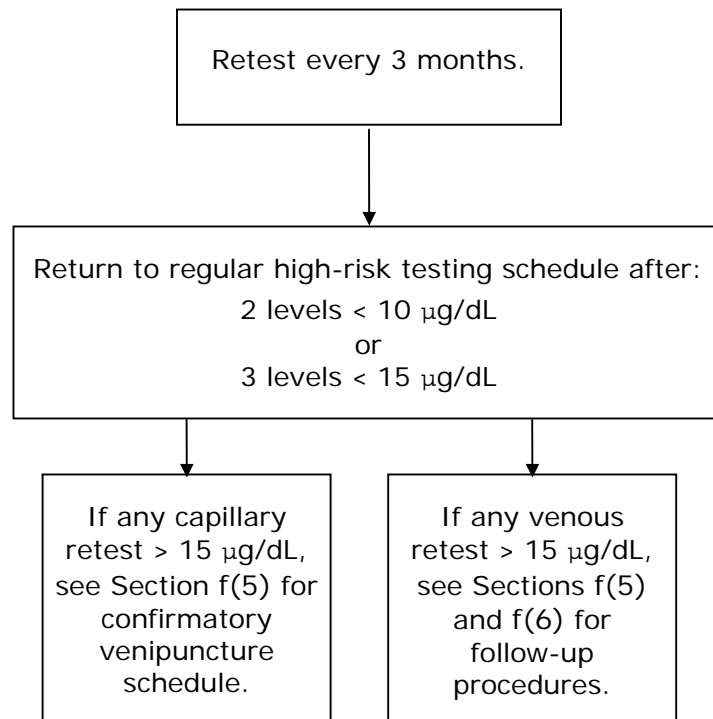
If venous level 15-19 $\mu\text{g/dL}$, see [Follow-up of Elevated Venous Blood Leads \(15-19 \$\mu\text{g/dL}\$ \)](#).

If venous level ≥ 20 $\mu\text{g/dL}$, see [Follow-up of Elevated Venous Levels \(\$\geq 20\$ \$\mu\text{g/dL}\$ \)](#).

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



(4) Follow-up of Elevated Blood Lead Levels (10-14 $\mu\text{g/dL}$)

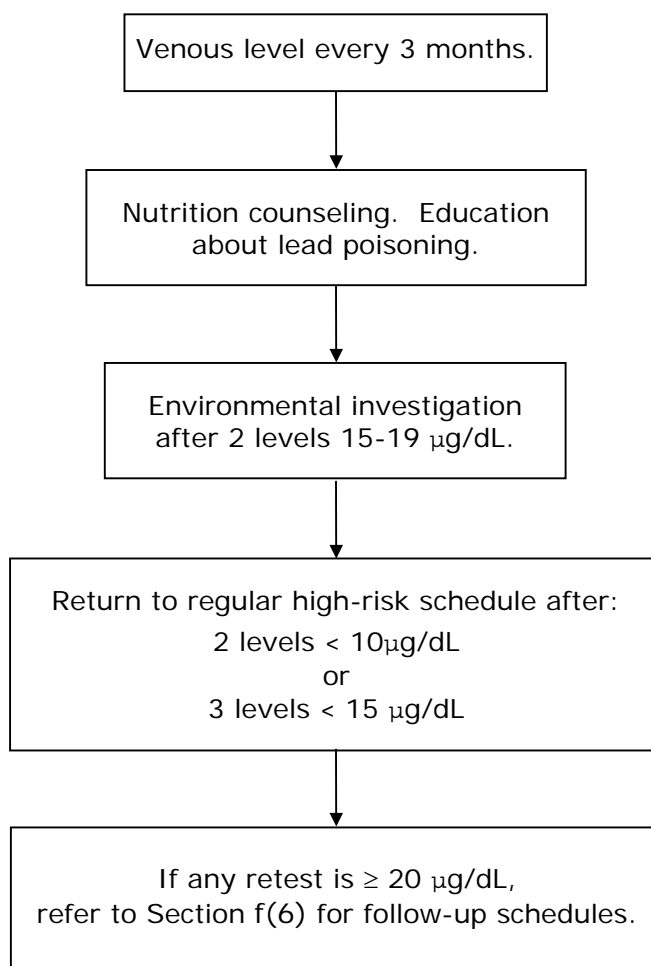


Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



(5) Follow-up of Elevated Venous Blood Leads (15-19 $\mu\text{g}/\text{dL}$)

All children who have had venous levels $\geq 15 \mu\text{g}/\text{dL}$ are considered “high” risk regardless of initial risk assessment.

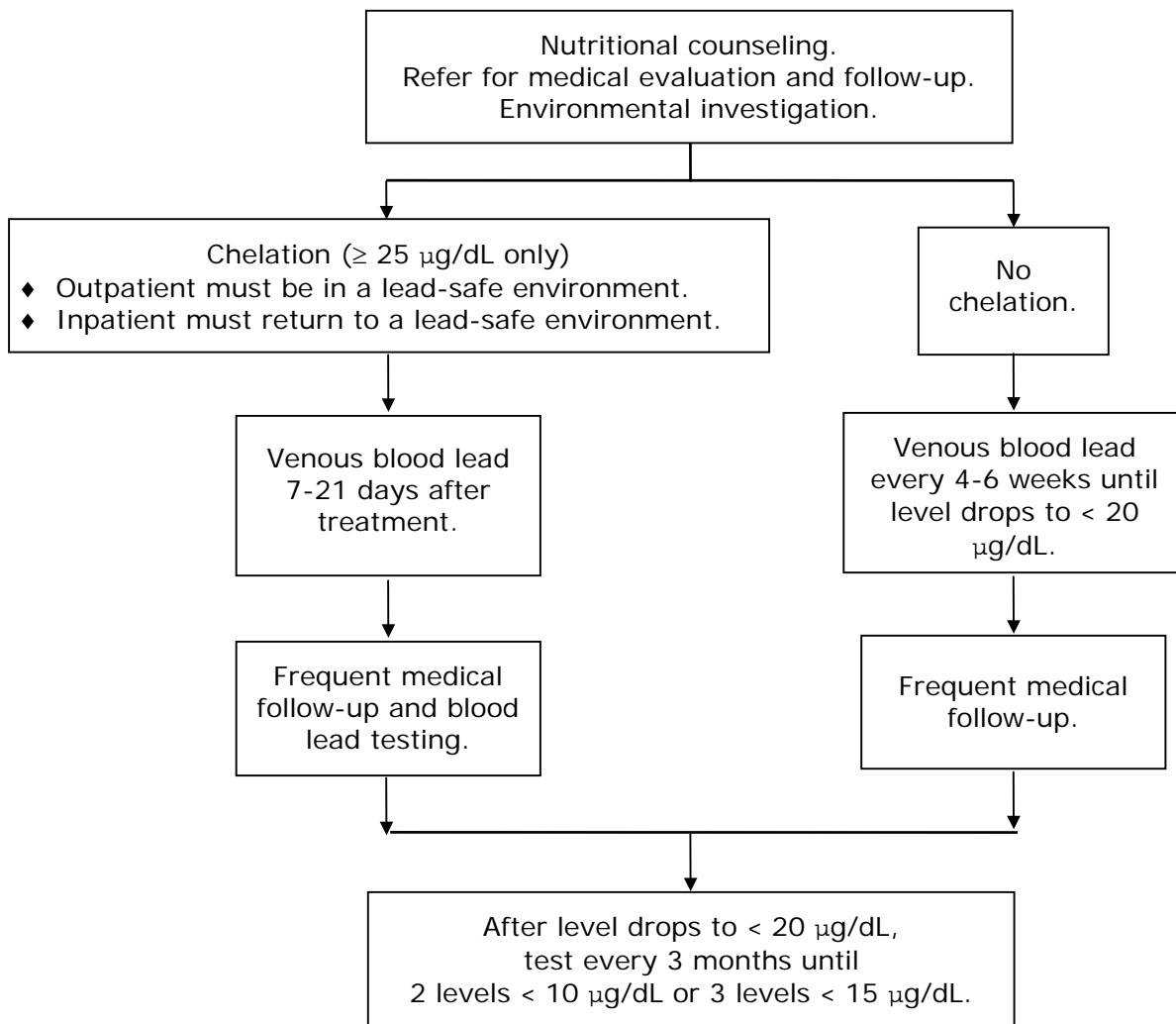


See [Timelines for Medical and Nutritional Follow-up](#) and [Timelines for Environmental Follow-up](#) for guidance for referrals.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



(6) Follow-up of Elevated Venous Levels ($\geq 20 \mu\text{g/dL}$)

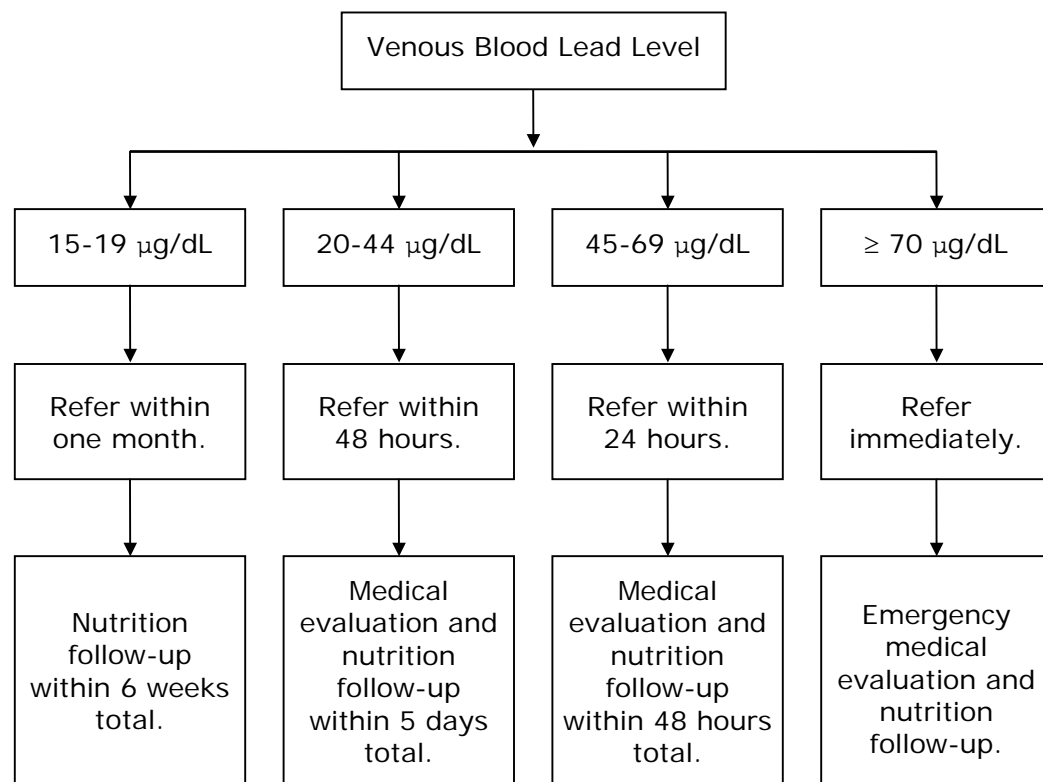


See [Timelines for Medical and Nutritional Follow-up](#) and [Timelines for Environmental Follow-up](#) for guidance for referrals.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



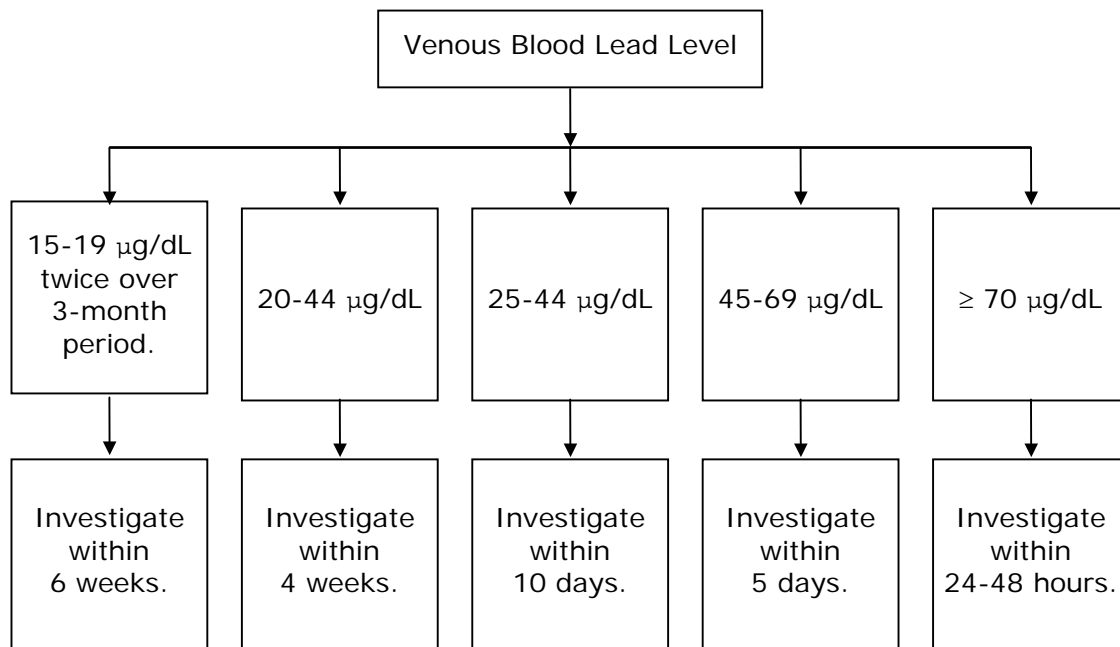
(7) Timelines for Medical and Nutritional Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



(8) Timelines for Environmental Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).


g. Cervical Papanicolaou (PAP) Smear

Regular cervical Papanicolaou (PAP) smears are recommended for all females who are sexually active or whose sexual history is thought to be unreliable at age 18. High-risk for cancer in situ are those who:

- ◆ Begin sexual activity in early teen years, and
- ◆ Have multiple partners.

Sexually active females should receive family planning counseling, including pap smears, self breast examinations, and education on prevention of sexually transmitted diseases.

Make a referral for further evaluation, diagnosis, or treatment when the smear demonstrates an abnormality. If first smear is unsatisfactory, repeat as soon as possible.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 65
		Date September 1, 2007

h. Gonorrhea Test

Testing for gonorrhea may be done on persons with:

- ◆ Multiple sexual partners or a sexual partner with multiple contacts.
- ◆ Sexual contacts with a person with culture-proven gonorrhea.
- ◆ A history of repeated episodes of gonorrhea.

Discuss how to use contraceptives and make them available. Offer education on prevention of sexually transmitted diseases.

i. Chlamydia Test

Routine testing of sexually active women for chlamydia trachomatis is recommended for asymptomatic persons at high risk for infection (e.g., age less than 25, multiple sexual partners with multiple sexual contacts). For recent sexual partners of persons with positive tests for STD, also provide:

- ◆ Education on prevention of sexually transmitted diseases.
- ◆ Education on the importance of contraception to prevent pregnancy.

4. Other Services

Other services that must be included in the screening examination are:

- ◆ [Immunizations](#)
- ◆ [Assessment of nutritional status](#)
- ◆ [Vision screening](#)
- ◆ [Hearing screening](#)


a. Immunization

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90% of children to have recommended immunizations by their second birthday.

Standards published by the National Vaccine Advisory Committee in February 2002 reflect changes and challenges in vaccine delivery.

Every time children are seen, screen their immunization status and administer appropriate vaccines. (See [ACIP Recommendations](#).)

You can obtain information about immunizations by contacting 1-800-232-4636 or 1-800-831-6293.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	66 Date September 1, 2007

Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See [Contraindications and Precaution for Immunization](#) for a guide to contraindications to immunization.
<http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>

When multiple vaccines are needed, administer vaccines simultaneously to decrease the number of children lost to follow-up. Do this particularly in high-risk populations who tend to be transient and noncompliant with recommendations for routine health maintenance visits.

Under the leadership of National Vaccine Advisory Committee (NVAC), standards were recently revised (<http://www.cdc.gov/vaccines/recs/vac-admin/>). The revised standards focus on:

- ◆ Making vaccines easily accessible.
- ◆ Effectively communicating vaccination information.
- ◆ Implementing strategies to improve vaccination rates.
- ◆ Developing community partnerships to reach target patient populations.

Provide the recommended childhood immunization schedule for the United States for January-December of the current year. These recommendations are approved by:

- ◆ The Advisory Committee on Immunization Practices (ACIP).
- ◆ The American Academy of Pediatrics.
- ◆ The American Academy of Family Physicians.

The recommended childhood and adolescent immunization schedule can be accessed on the following web sites: <http://www.cdc.gov/vaccines>, www.aap.org, or www.aafp.org.

b. Nutritional Status

To assess nutritional status, include:

- ◆ Accurate measurements of height and weight.
- ◆ A laboratory test to screen for iron deficiency anemia (see Hgb/Hct procedures on [Hemoglobin and Hematocrit](#) for suggested screening ages).



- ◆ Questions about dietary practices to identify:
 - Diets that are deficient or excessive in one or more nutrients.
 - Food allergy, intolerance, or aversion.
 - Inappropriate dietary alterations.
 - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).
- ◆ Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability.
- ◆ If feasible, cholesterol measurement for children over two years of age who have increased risk for cardiovascular disease according to the following criteria:
 - Parents or grandparent, at 55 years of age or less, underwent diagnostic coronary arteriography and was found to have coronary atherosclerosis or suffered a documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
 - A parent who has been found to have high blood cholesterol (240 mg/dL or higher).

(1) Medical Evaluation Indicated (0-12 months)

Use the following criteria for referring an infant for further medical evaluation due to nutrition status:

- ◆ Measurements:
 - Weight/height < 5th percentile or > 95th percentile (NCHS charts).
 - Weight/age < 5th percentile.
 - Major change in weight/height percentile rank. (A 25 percentile or greater shift in ranking.)
 - Flat growth curve. (Two months without an increase in weight/age of an infant below the 90th percentile weight/age.)



♦ Laboratory tests:

- < Hct 32.9%
- < Hgb 11 gm/dL (6-12 months)
- ≥ 15 $\mu\text{g/dL}$ blood lead level

♦ Health problems:

- Metabolic disorder.
- Chronic disease requiring a special diet.
- Physical handicap or developmental delay that may alter nutritional status.

♦ Physical examination: Abnormality of hair, skin, nails, eyes, teeth, or gums that indicates poor nutrition; disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

(2) Medical Evaluation Indicated (1-10 years)

Use these criteria for referring a child for further medical evaluation of nutrition status:

♦ Measurements:

- Weight/length < 5th percentile or > 95th percentile for 12-23 months.
- BMI for age < 5th percentile or > 95th percentile for 24 months and older.
- Weight/Age < 5th percentile.
- Major change in weight/height percentile rank. (A 25 percentile or greater shift in ranking.)
- Flat growth curve:

Age	Indicator
12 to 36 months	Two months without an increase in weight per age of a child below the 90th percentile weight per age.
3 to 10 years	Six months without an increase in weight per age of a child below the 90th percentile weight per age.



♦ Laboratory tests:

Age	HCT %	HGB gm/dL
1 up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.4
8 up to 10 years	35.4	11.9

♦ Health problems:

- Chronic disease requiring a special diet.
- Metabolic disorder.
- Family history of hyperlipidemias.
- Physical handicap or developmental delay that may alter nutritional status.

- ♦ Physical examination: Abnormality of hair, skin, nails, eyes, teeth, or gums that indicates poor nutrition; disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

(3) Medical Evaluation Indicated (11-21 years)


Use these criteria for referring adolescents for further medical evaluation of nutritional status:

♦ Laboratory tests

Age	FEMALE		MALE	
	HCT %	HGB gm/dL	HCT %	HGB gm/dL
11 up to 12	35.4	11.9	35.4	11.9
12 up to 15	35.7	11.8	37.3	12.5
15 up to 18	35.9	12.0	39.7	13.3
18 up to 21	35.7	12.0	39.9	13.6

♦ Health problems:

- Chronic disease requiring a special diet.
- Physical handicap or developmental delay that may alter nutritional status.
- Metabolic disorder.
- Substance use or abuse.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	70 Date September 1, 2007

- Family history of hyperlipidemias.
- Any behaviors intended to change body weight, such as self-induced vomiting, bingeing and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise.
- Physical examination. Abnormality of hair, skin, nails, eyes, teeth, or gums that indicates poor nutrition; disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

Source: *Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents*. U.S. Department of Health and Human Services, September 1991.

c. Vision


Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

(1) Birth Through Two Years of Age

Eye evaluations of infants and children birth through two years of age should include:

- ◆ Eyelids and orbits.
- ◆ External examinations.
- ◆ Eye muscle balance.
- ◆ Pupils.
- ◆ Red reflex.
- ◆ Motility.
- ◆ Monocular fixational ability/assessment.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 71
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

(2) Two to Four Years of Age

In addition to all the eye evaluations listed for infants and young children, two additional measures should be included. Beginning as early as age 2½ years, children should receive objective vision testing using picture cards. (See the following [chart](#) for suggested tests.)

Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the child is untestable on the second attempt.

In addition to visual acuity testing, children four years old may cooperate by fixating on a toy while the ophthalmoscope is used to evaluate the optic nerve and posterior eye structures.

(3) At Five Years and Older

Children five years and older should receive all the previously described eye examinations and screening described for younger children.


During the preschool years, muscle imbalance testing is very important. The guidelines above suggest assessing muscle imbalance by use of the corneal light reflex test, unilateral cover test at near and far distance, and random-dot-E test for depth perception.

As the child reaches school age, refractive errors that may require eyeglasses for correction become important. The most common refractive error is hyperopia or far-sightedness. Hyperopia can cause problems in performing close work. Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning-related vision problems.



VISION SCREENING GUIDELINES		
Function: Recommended Tests	Referral Criteria	Comments
Distance visual acuity: <ul style="list-style-type: none"> ◆ Snellen letters ◆ Snellen numbers ◆ Tumbling E ◆ HOTV ◆ Picture tests <ul style="list-style-type: none"> • Allen figures • LH test 	Ages 3-5 years: <ol style="list-style-type: none"> 1. <4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., <10/20 or 20/40) or 2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40) Ages 6 years and older: <ol style="list-style-type: none"> 1. <4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., <10/15 or 20/30) 2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30) 	<ol style="list-style-type: none"> 1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older. 2. Testing distance of 10 ft is recommended for all visual acuity tests. 3. A line of figures is preferred over single figures. 4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye.
Ocular alignment: <ul style="list-style-type: none"> ◆ Unilateral cover test at 10 ft or 3 m or ◆ Random-dot-E stereo test at 40 cm (630 s of arc) 	Any eye movement <4 of 6 correct	

Source: Vision screening guidelines developed by the AAP Section on Ophthalmology Executive Committee, 1991-1992. *Pediatrics*, Vol. 98 No. 1, July 1996.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 73
		Date September 1, 2007

d. Hearing

Objective screening of hearing for all neonates is now recommended by multiple professional medical, audiology, and early childhood education groups. Objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with progressive hearing loss.

Thus, objective hearing screening for all children should be a regular procedure conducted during well-child health screening appointments according to the periodicity schedule. Using high risk factor subjective screening methods is no longer an acceptable alternative to objective hearing screening during early childhood.


Objective hearing screening should be performed on all infants by age one month. Newborn infants who have **not** had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies. There are multiple public and private audiologists serving infants and toddlers.

Other types of objective hearing screening, such as “play audiometry” may begin as soon as a child is developmentally able to understand the procedure and cooperate. Audiometry is typically performed at frequencies of 500, 1000, 2000, 4000, and 6000 Hz at 20 decibels for both ears.

Subjective screening of hearing may be performed by history and observation during health visits occurring between the appointed times for objective hearing screening according to the periodicity schedule.

A child of any age who has not had objective hearing screening should be **referred** for audiology evaluation to rule out congenital hearing loss. The following children should also be referred for objective audiology evaluation:

- ◆ A child with congenital anomaly of the ear, nose, throat, or kidney
- ◆ A child with behavior problems
- ◆ A child with developmental delay of onset of speech
- ◆ A child with recurrent upper respiratory infections
- ◆ A child with a family history of hearing loss
- ◆ A child who does not respond to pure tone testing at any of the levels screened

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	74 <hr/> Date September 1, 2007

If the parent has any concern about the child's hearing, refer the child for objective audiology evaluation.

Unless a medical problem is apparent, an audiological examination is usually needed before referral or in conjunction with the referral to medical specialist.

D. BASIS OF PAYMENT

Local education agencies are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Bill all procedures in whole units of service. Except as noted in the coding chart, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

E. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied. Use the diagnosis code for the identified medical condition. Procedure codes applicable to local education agency services are as follows.

In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. Possible modifiers are shown below:

<u>Modifier</u>	<u>Definition</u>
AH	Clinical psychologist
AJ	Social worker
GN	Speech pathologist
GO	Occupational therapist
GP	Physical therapist
HO	Masters degree (use for guidance counselor)
HQ	Group setting
TD	RN
TE	LPN
TM	Individual Education Program contracted services
U9	Other health associate
UA	Audiologist



Code Modifier Description

Audiology

V5008		Hearing screening per encounter
92506	UA	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status 15-minute unit
92507	UA	Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual 15-minute unit
92508	UA	Treatment of speech, language, voice, communication, and/or auditory processing disorder, group 15-minute unit
92507	TM	Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual by contracted staff 15-minute unit

Behavior Services

T1023	Varies	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter. Use applicable modifier.
96150		Health and behavior assessment, per 15-minute unit
96152		Health and behavior intervention, per 15-minute unit
96152	TM	Health and behavior intervention by contracted staff, per 15-minute unit
96153		Health and behavior intervention, group (2 or more) per 15-minute unit

Medical Transportation

A0110		Non-emergency transportation and bus round trip
A0100		Non-emergency transportation: taxi round trip
A0130		Non-emergency transportation; wheelchair van round trip
A0090		Non-emergency transportation volunteer per mile
A0120		Non-emergency transportation mini-bus, mountain area transports, other non-profit transportation system round trip
T2001	U9	Non-emergency transportation; patient attendant/escort, per 15-minute unit (Use modifier U9 for non RN/LPN services.)
T2001	HQ	Nonemergency transportation; patient attendant/escort, group, per 15-minute unit
T2001	HQU9	Nonemergency transportation; patient attendant/escort, group, non RN/LPN, per 15-minute unit



Code Modifier Description

Nursing Service

T1023	TD or TE	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter. (TD = RN TE = LPN)
T1001		Nursing assessment/evaluation, per 15-minute unit
T1002		RN services, per 15-minute unit
T1003		LPN services, per 15-minute unit
H0033		Oral medication administration, 15-minute unit
99199		Unlisted service, 60-minute unit
T1002	TM	RN services contracted services, 15-minute unit
T1003		LPN services contracted services, 15-minute unit
T1002	HQ	RN services group, 15-minute unit
T1003	HQ	LPN services group, 15-minute unit
T1999		Miscellaneous therapeutic items and supplies (NOTE: This code is not payable for children who reside in nursing facilities. Use code T5999.)
T5999		Miscellaneous therapeutic items and supplies for children who reside in nursing facilities

Occupational Therapy

T1023	GO	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
97003		Occupational therapy evaluation, 15-minute unit
97530	GO	Therapeutic activities, direct patient contact by the provider, 15-minute unit
97535	GO	Self-care or home management training, 15-minute unit
97537	GO	Community or work reintegration, 15-minute unit
97150	GO	Therapeutic procedures, group, 15-minute unit
97530	TM	Therapeutic activities, direct patient contact by the provider, contracted staff, 15-minute unit
97537	TM	Community or work reintegration by contracted staff, 15-minute unit
97535	TM	Self-care or home management training by contracted staff, 15-minute unit



Code Modifier Description

Personal Health

T1019		Personal care services, 15-minute unit
T1020		Personal care services, per diem
T1019	TM	Personal care services, by contracted staff, 15-minute unit
T1020		Use this code when services are provided for 50% or more of a school day

Physical Therapy

T1023	GP	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
97001		Physical therapy evaluation, per 15-minute unit
97530		Therapeutic activities, direct patient contact by the provider, 15-minute unit
97116		Gait training, per 15-minute unit
97535		Self-care or home management training, per 15-minute unit
97537		Community or work reintegration, per 15-minute unit
97150		Therapeutic procedures, group, per 15-minute unit
97530	TM	Therapeutic activities, direct patient contact by the provider, by contracted staff, 15-minute unit
97116	TM	Gait training by contracted staff, 15-minute unit
97535	TM	Self-care or home management training by contracted staff, 15-minute unit
97537	TM	Community or work reintegration by contracted staff, 15-minute unit

Psychological Services

T1023	AH	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
96101		Psychological testing with interpretation and report, per 60-minute unit
90804	AH	Individual psychotherapy, 30-minute unit
90853	AH	Group psychotherapy, 30-minute unit
90804	TM	Individual psychotherapy by contracted staff, 30-minute unit



Code Modifier Description

Speech Language

V5362		Speech screening per encounter
V5363		Language screening per encounter
92506	GN	Evaluation of speech, language, voice, communication, auditory process, and aural rehabilitation status, per 15-minute unit
92507	GN	Treatment of speech, language, voice, communication, or auditory processing disorder, individual, per 15-minute unit
92508	GN	Treatment of speech, language, voice, communication, or auditory processing disorder, group, per 15-minute unit
92507	TM	Treatment of speech, language, voice, communication, or auditory processing disorder, individual by contracted staff, per 15-minute unit

Social Work – Counseling Service

T1023	AJ or HO	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter. (AJ = social worker; HO = masters degree/counseling)
H0031		Mental health assessment by non-physician, per 15-minute unit
90804	AJ	Individual psychotherapy, 30-minute unit
90853	AJ	Group psychotherapy, 30-minute unit
H0046	HO	Mental health services by counselor, 15-minute unit
H0046	TM	Mental health services, not otherwise specified, by contracted staff, per 15-minute unit

Vision Service

99173		Screening test of visual acuity, quantitative, bilateral, per 15-minute unit
99172		Visual function screening, per 15-minute unit
92012		Ophthalmological services, exam and evaluation, per 15-minute unit
92014		Comprehensive services, established patient, per 15-minute unit
92499		Unlisted service (vision services in a group setting), per 15-minute unit
92014	TM	Comprehensive services, established patient by contracted staff, per 15-minute unit



Code Modifier Description

Orientation and Mobility

97139 Unlisted therapeutic procedure, 15-minute unit

Service Coordination

T1017 Targeted case management, per 15-minute unit

Vaccinations

Local education agencies that wish to administer to Medicaid members vaccines that are available through the Vaccines for Children (VFC) program shall enroll in the VFC program. Vaccines available through the VFC program include:

Code Description

90702 Diphtheria and tetanus toxoids (DT) vaccine
90700 Diphtheria, tetanus, acellular pertussis (DTaP)
90748 Hemophilus influenza B (HIB) and hepatitis B vaccine
90723 Diphtheria, tetanus toxoids, and acellular pertussis (DTaP), Hepatitis B poliovirus (IPV) vaccine
90721 Diphtheria, tetanus toxoids, and acellular pertussis (DTaP), hemophilus influenza B (HIB) vaccine
90645 Hemophilus influenza B (HIB) HbOC conjugate (four-dose schedule)
90646 Hemophilus influenza B (HIB) PRP-D conjugate (booster only)
90647 Hemophilus influenza B (HIB) PRP-Omp conjugate (three-dose schedule)
90648 Hemophilus influenza B (HIB) PRP-T conjugate (four-dose schedule)
90633 Hepatitis A, pediatric/adolescent (2 dose schedule)
90743 Hepatitis B vaccine; adolescent (two-dose schedule), for intramuscular use
90744 Hepatitis B vaccine; pediatric/adolescent dosage (three-dose schedule), for intramuscular use
90649 Human papilloma virus (HPV)
90655 Influenza virus, preservative free, for children 6-35 months of age
90656 Influenza virus vaccine, preservative free, administered to 3 years and older
90660 Influenza virus vaccine, live, for intranasal use
90657 Influenza vaccine, children 6-35 months
90658 Influenza vaccine, children 3 years or older
90710 Measles, mumps, rubella, varicella (MMRV)
90707 Measles, mumps, and rubella virus vaccine (MMR), live
90734 Meningococcal conjugate vaccine



<u>Code</u>	<u>Description</u>
90669	Pneumococcal conjugate, children under 5
90713	Poliovirus vaccine (IPV)
90714	Tetanus and diphtheria toxoids (TD), adsorbed, preservative free, children 7 years and older
90715	Tetanus, diphtheria toxoids and acellular pertussis (DTaP), children 7 years and older
90718	Tetanus and diphtheria toxoids (TD) adsorbed, for use in patients aged seven years or older, for intramuscular or jet injection
90716	Varicella vaccine

When a student receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

For VFC vaccine, bill code 90471 and 90472 for vaccine administration in addition to the CPT code. The charges in box 24F should be "0." Charge your cost for 90471 and 90472.

Primary and Preventive Services

Preventive Services: New Patient

Initial preventive medicine evaluation and management including a comprehensive history, a comprehensive examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient:

99381	Infant (age under 1 year)
99382	Early childhood (age 1 through 4 years)
99383	Late childhood (age 5 through 11 years)
99384	Adolescent (age 12 through 17 years)
99385	18-39 years

Preventive Services: Established Patient

Periodic preventive medicine reevaluation and management including a comprehensive history, comprehensive examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient:

99391	Infant (age under 1 year)
99392	Early childhood (age 1 through 4 years)
99393	Late childhood (age 5 through 11 years)
99394	Adolescent (age 12 through 17 years)
99395	18-39 years



Primary Services: New Patient

Office or other outpatient visit for the evaluation and management of a new patient:

- 99201 Presenting problems are self limited or minor. Requires these three key components:
- ◆ a problem-focused history;
 - ◆ a problem-focused examination; and
 - ◆ straightforward medical decision making.
- Physicians typically spend 10 minutes face-to-face with the patient or family.
- 99202 Presenting problems are of low to moderate severity. Requires these three key components:
- ◆ an extended problem-focused history;
 - ◆ an expanded problem-focused examination; and
 - ◆ straightforward medical decision making.
- Physicians typically spend 20 minutes face-to-face with the patient or family.
- 99203 Presenting problems are of moderate severity. Requires these three key components:
- ◆ a detailed history;
 - ◆ a detailed examination; and
 - ◆ medical decision making of low complexity.
- Physicians typically spend 30 minutes face-to-face with the patient or family.
- 99204 Presenting problems are of moderate to high severity. Requires these three key components:
- ◆ a comprehensive history;
 - ◆ a comprehensive examination; and
 - ◆ medical decision making of moderate complexity.
- Physicians typically spend 45 minutes face-to-face with the patient or family.
- 99205 Presenting problems are of moderate to high severity. Requires these three key components:
- ◆ a comprehensive history;
 - ◆ a comprehensive examination; and
 - ◆ medical decision making of moderate complexity.
- Physicians typically spend 60 minutes face-to-face with the patient or family.



Primary Services: Established Patient

Office or other outpatient visit for the evaluation and management of an established patient:

- 99211 Presenting problems are minimal and may not require the presence of a physician. Typically, 5 minutes are spent performing or supervising these services.
- 99212 Presenting problems are self limited or minor. Requires at least two of these three key components:
- ◆ a problem-focused history;
 - ◆ a problem-focused examination; and
 - ◆ straightforward medical decision making.
- Physicians typically spend 10 minutes face-to-face with the patient or family.
- 99213 Presenting problems are of low to moderate severity. Requires at least two of these three key components:
- ◆ an extended problem-focused history;
 - ◆ an expanded problem-focused examination; and
 - ◆ medical decision making of low complexity.
- Physicians typically spend 15 minutes face-to-face with the patient or family.
- 99214 Presenting problems are of moderate to high severity. Requires at least two of these three key components:
- ◆ a detailed history;
 - ◆ a detailed examination; and
 - ◆ medical decision making of moderate complexity.
- Physicians typically spend 25 minutes face-to-face with the patient or family.
- 99215 Presenting problems are of moderate to high severity. Requires at least two of these three key components:
- ◆ a comprehensive history;
 - ◆ a comprehensive examination; and
 - ◆ medical decision making of high complexity.
- Physicians typically spend 40 minutes face-to-face with the patient or family.



Consultation Services:

Office consultation for a new or an established patient:

- 99241 Presenting problems are self limited or minor. Requires these three key components:
- ◆ a problem-focused history;
 - ◆ a problem-focused examination; and
 - ◆ straightforward medical decision making.
- Physicians typically spend 15 minutes face-to-face with the patient or family.
- 99242 Presenting problems are of low severity. Requires these three key components:
- ◆ an extended problem-focused history;
 - ◆ an expanded problem-focused examination; and
 - ◆ straightforward medical decision making.
- Physicians typically spend 30 minutes face-to-face with the patient or family.
- 99243 Presenting problems are of moderate severity. Requires these three key components:
- ◆ a detailed history;
 - ◆ a detailed examination; and
 - ◆ medical decision making of low complexity.
- Physicians typically spend 40 minutes face-to-face with the patient or family.
- 99244 Presenting problems are of moderate to high severity. Requires these three key components:
- ◆ a comprehensive history;
 - ◆ a comprehensive examination; and
 - ◆ medical decision making of moderate complexity.
- Physicians typically spend 60 minutes face-to-face with the patient or family.
- 99245 Presenting problems are of moderate to high severity. Requires these three key components:
- ◆ a comprehensive history;
 - ◆ a comprehensive examination; and
 - ◆ medical decision making of moderate complexity.
- Physicians typically spend 80 minutes face-to-face with the patient or family.



Testing

Bill specific laboratory and testing services as follows:

99000	Draw fee
85014	Hematocrit
85018	Hemoglobin
81000	Urinalysis

F. CLAIM FORM

Claims for local education agency services are billed on federal form CMS-1500, *Health Insurance Claim Form*. To view a sample of this form on line, click [here](#).

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives a brief description of the information to be entered and whether providing information in that field is required, optional, or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	REQUIRED. Check the applicable program block.
1a.	INSURED'S ID NUMBER	REQUIRED. Enter the Medicaid member's Medicaid number, found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	REQUIRED. Enter the last name, first name, and middle initial of the Medicaid member.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY										STATE										CITY										STATE																													
ZIP CODE										TELEPHONE (Include Area Code) ()										ZIP CODE										TELEPHONE (Include Area Code) ()																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																											
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # () a. NPI b.																																							

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
3.	PATIENT'S BIRTHDATE	OPTIONAL. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	OPTIONAL. Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	REQUIRED, IF KNOWN. Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	SITUATIONAL. Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	REQUIRED, IF KNOWN. Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
10d.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	OPTIONAL. For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	<p>REQUIRED. If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed.</p> <p>If there is no other insurance, check "no."</p> <p>If you have received a denial of payment from another insurance, check both "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record.</p> <p>Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.</p> <p>NOTE: Auditing will be performed on a random basis to ensure correct billing.</p>
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	SITUATIONAL. Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	SITUATIONAL. Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	OPTIONAL. No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	CONDITIONAL. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		OPTIONAL. No entry required.
17b.	NPI	SITUATIONAL. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	OPTIONAL. No entry required.
19.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
20.	OUTSIDE LAB	OPTIONAL. No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	REQUIRED. Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	SITUATIONAL. If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE	REQUIRED. Enter month, day, and year under both the "From" and "To" columns for each procedure, service, or supply. If the "From-To" dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a monthly basis, spanning or overlapping billing months could cause the entire claim to be denied.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	<p>REQUIRED. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none">11 Office12 Home21 Inpatient hospital22 Outpatient hospital23 Emergency room – hospital24 Ambulatory surgical center25 Birthing center26 Military treatment facility31 Skilled nursing32 Nursing facility33 Custodial care facility34 Hospice41 Ambulance – land42 Ambulance – air or water51 Inpatient psychiatric facility52 Psychiatric facility – partial hospitalization53 Community mental health center54 Intermediate care facility/mentally retarded55 Residential substance abuse treatment facility56 Psychiatric residential treatment center61 Comprehensive inpatient rehabilitation facility62 Comprehensive outpatient rehabilitation facility65 End-stage renal disease treatment71 State or local public health clinic72 Rural health clinic81 Independent laboratory99 Other unlisted facility
24. C	EMG	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. D	PROCEDURES, SERVICES OR SUPPLIES	REQUIRED. Enter the codes for each of the dates of service. Do not list services for which no fees were charged. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	REQUIRED. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. Do not write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	\$ CHARGES	REQUIRED. Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	REQUIRED. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	SITUATIONAL. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	OPTIONAL. No entry required.
24. J	RENDERING PROVIDER ID #	SITUATIONAL. The "rendering provider" is the practitioner who provided, supervised, or ordered the service. In the lower portion, enter the NPI of the provider rendering the service when the NPI given in field 33 is that of a group or is not that of the treating provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
25.	FEDERAL TAX ID NUMBER	OPTIONAL. No entry required.
26.	PATIENT'S ACCOUNT NUMBER	FOR PROVIDER USE. Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	OPTIONAL. No entry required.
28.	TOTAL CLAIM CHARGE	REQUIRED. Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	SITUATIONAL. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	REQUIRED. Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	REQUIRED. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	REQUIRED. Enter the name and address associated with the rendering provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
32a.	NPI	OPTIONAL. Enter the NPI of the facility where services were rendered.
32b.		OPTIONAL. No entry required.
33.	BILLING PROVIDER INFO AND PHONE #	REQUIRED. Enter the complete name and address of the billing provider or service provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification or during enrollment. To view the ZIP code provided, access imeservices.org .
33a.	NPI	REQUIRED. Enter the ten-digit NPI of the billing provider. A provider that does not meet the definition of "health care provider" and therefore does not meet the criteria to receive an NPI should enter the ten-digit provider number assigned by IME (begins with "X00"). If this number identifies a group or an individual provider other than the provider of service, the rendering provider's NPI must be entered in field 24J for each line. NOTE: The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the NPI provided, access imeservices.org .
33b.		REQUIRED. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the taxonomy code provided, access imeservices.org .

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provider Name _____

NPI Billing Provider Number

--	--	--	--	--	--	--	--	--	--

Member Name _____

Member State ID Number


--	--	--	--	--	--	--	--

Date of Service ____/____/____

Type of Document

Return this document with attachments to:

IME Claims
P.O. Box 150001
Des Moines, IA 50315

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 93
	Local Education Agency Chapter III. Provider-Specific Policies	Date September 1, 2007

2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ **Complete** form 470-3969, *Claim Attachment Control*. To view a sample of this form on line, click [here](#). Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number.

If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

- ◆ **Staple** the additional information to the *Claim Attachment Control*. Do **not** attach a paper claim.
- ◆ **Mail** the *Claim Attachment Control* with attachments to:

Iowa Medicaid Enterprise
 PO Box 150001
 Des Moines, IA 50315


Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

G. REMITTANCE ADVICE

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	Local Education Agency Chapter III. Provider-Specific Policies	94 <hr/> Date September 1, 2007

- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.
- ◆ **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

IAMC8000-R001 (CP-O-12)
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E A D V I C E

4

TO: 1

R.A. NO.: 3 2 6

WARR NO.: 9 3 9

DATE PAID: 10/22/07 PROV. NUMBER: 5

PAGE: 6 1

**** PATIENT NAME ****	RECIP ID /	TRANS-CONTROL-NUMBER /	BILLED	OTHER	PAID BY	COPAY	MED RCD NUM /						
LAST	FIRST MI	LINE	SVC-DATE	PROC/MODS	UNITS	AMT.	SOURCES	MCAID	AMT.	PERF. PROV.	S	EOB	EOB

* * * CLAIM TYPE: HCFA 1500 7

* * * CLAIM STATUS: PAID 8

ORIGINAL CLAIMS:

9	10	11	12	13	14	15	16	17
3-07290-00-015-0941-00	21	172.00	0.00	85.07	1.00	000 000		
01 10/04/07 99242 20	1	172.00	22	23	24	25	26	27
3-07292-00-009-0053-00	69.00	0.00	32.36	0.00	000 000			
01 07/06/07 99212	1	69.00	32.36	0.00	F 000 000			
3-07288-00-010-0484-00	298.00	0.00	145.03	0.00	000 000			
01 07/11/07 99212 25	1	69.00	32.36	0.00	F 000 000			
02 07/11/07 29405	1	197.00	112.67	0.00	F 000 000			
03 07/11/07 A4590	1	32.00	0.00	0.00	K 177 000			
0-07281-22-009-0270-00	128.00	0.00	71.46	0.00	000 000			
01 06/14/07 20550	1	122.00	68.06	0.00	F 000 000			
02 06/14/07 J3301	2	6.00	3.40	0.00	F 000 000			

4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS.. 667.00 0.00 333.92 1.00

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 2

**** PATIENT NAME **** RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /
LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB

* * * CLAIM TYPE: HCFA 1500

* * * CLAIM STATUS: DENIED

ORIGINAL CLAIMS:

		3-07289-00-011-0880-00		69.00	0.00	0.00	0.00	499 000
01	07/12/07	99212	1	69.00		0.00	0.00	K 000 000
1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..				69.00	0.00	0.00	0.00	

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 3

28 REMITTANCE T O T A L S
PAID ORIGINAL CLAIMS: NUMBER OF CLAIMS 4 ----- 667.00 333.92
PAID ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0 ----- 0.00 0.00
DENIED ORIGINAL CLAIMS: NUMBER OF CLAIMS 1 ----- 69.00 0.00
DENIED ADJUSTMENT CLAIMS: NUMBER OF CLAIMS 0 ----- 0.00 0.00
PENDED CLAIMS (IN PROCESS): NUMBER OF CLAIMS 0 ----- 0.00 0.00
AMOUNT OF CHECK: ----- 333.92

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

29 177 THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM. 1
499 INVALID OR MISSING MEDIPASS REFERRAL FOR RECIPIENT. 1



2. Remittance Advice Sample and Field Descriptions

To view a sample of the *Remittance Advice* on line, click [here](#).


NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	<i>Remittance Advice</i> page number.
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: <ul style="list-style-type: none">• Paid. Claims for which reimbursement is being made.• Denied. Claims for which no reimbursement is being made.• Suspended. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.



NO.	FIELD NAME	DESCRIPTION
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the <i>Remittance Advice</i> for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.



NO.	FIELD NAME	DESCRIPTION
27.	S	Allowed charge source code: B Billed charge F Fee schedule M Manually priced N Provider charge rate P Group therapy Q EPSDT total screen over 17 years R EPSDT total under 18 years S EPSDT partial over 17 years T EPSDT partial under 18 years U Gynecology fee V Obstetrics fee W Child fee
28.	Remittance totals	(Found at the end of the <i>Remittance Advice</i>): <ul style="list-style-type: none">• Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.• Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid.• Number of denied original claims and the amount billed by the provider.• Number of denied adjusted claims and the amount billed by the provider.• Number of pended claims (in process) and the amount billed by the provider.• Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.

 Medicaid Enterprise Department of Human Services	Provider and Chapter Local Education Agency Chapter III. Provider-Specific Policies	Page 98
		Date September 1, 2007

H. MEDICAID BILLING REMITTANCE

The IME uses form 470-3816, *Medicaid Billing Remittance*, to notify providers of the amount of the non-federal share of the Medicaid reimbursement paid to the provider in the previous month. To view a sample of this form on line, click [here](#). It also includes the total of the non-federal share and 75% of the federal share.

Please send the payment for the non-federal share within 30 days of the date on the form. This form must accompany the payment for proper crediting.

- ◆ List the dollar amount of the non-federal share to be certified.
- ◆ List the month and year that the agency was paid.
- ◆ Enter an authorized signature and date.
- ◆ Enter the name of agency.

There will be detailed information provided with this form for your information.

MEDICAID BILLING REMITTANCE

[provider]

Provider # []

Invoice # []

Date []

The provider's share of the cost of the [provider] services. For the month of [month and year] your agency received \$[amount]. The total amount owed as the non-federal share is \$[amount] [For AEA only add: and 75% of the federal share for a total of \$(amount)]. This form must accompany payment for proper crediting.

All payments should be made to the Iowa Department of Human Services at the following address:

DHS Cashier 1st FL.
1305 E. Walnut St.
Des Moines IA 50319-0114

The amount of _____ for the month of _____ is enclosed.

Signature of Authorized Representative

Date

Agency Name

If you have questions or concerns please contact Sally Nadolsky at snadols@dhs.state.ia.us or (515)725-1142. Payment is due within 30 days of the date of this notice. Thank you for your assistance and timely payment.

cc: DHS, DE